

February 26, 2014

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

Dear Mr. Palmer:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Iowa section 1115 Medicaid demonstrations, entitled “Iowa Wellness Plan”, (Project # 11-W-00289/5) and “Iowa Marketplace Choice Plan”, (Project # 11-W-00288/5), under the authority of section 1115(f) of the Social Security Act (the Act) to ensure that the Special Terms and Conditions (STCs) reflect how the state is currently operating its demonstration.

Specifically, we are revising the STCs, the waiver and expenditure authorities approved on December 30, 2013, to reflect the following:

Iowa Wellness Plan

- CMS is clarifying the Waiver of Comparability to state that the demonstration population will be subject to an \$8 copay for non-emergency use of the emergency department and that copays applied to other Medicaid populations will not be imposed on the demonstration populations.
- CMS is clarifying STC 18 to state that the demonstration population will receive benefits described in the Iowa Wellness Plan alternative benefit plan.

Iowa Marketplace Choice Plan

- CMS is clarifying the Waiver of Comparability to state that the demonstration population will be subject to an \$8 copay for non-emergency use of the emergency department and that copays applied to other Medicaid populations will not be imposed on the demonstration populations.
- CMS is editing STC 17 to delete “from” and replace the eligible population with “incomes above” 100 percent of the federal poverty level.
- CMS is clarifying STC 30 to state that the demonstration population will receive benefits described in the Iowa Marketplace Choice alternative benefit plan.
- CMS is editing STC 35 to clarify the requirements for contracting with at least one FQHC and RHC, where FQHC or RHC services are available.

- CMS is editing STC 40 to delete “any access data standards and an updated monitoring protocol related to healthy behaviors to be met in year 2 (or subsequent years),” as well as, “Baseline and year 1 data regarding access and utilization.”

CMS has reviewed the changes and believes these changes are technical in nature. Most of the changes made to the STCs clarified language in the document based on the agreed terms between the state and CMS. Therefore, CMS has incorporated the technical changes into the latest version of the STCs, which are enclosed with this letter.

We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

/s/

Diane T. Gerrits
Director,
Division of State Demonstrations and Waivers

Enclosure

Cc: Elliot Fishman, CMCS
James Scott, CMS Atlanta Regional Office
Sandra Levels, CMS Atlanta Regional Office
Vanessa Sammy, CMCS

CENTERS FOR MEDICARE AND MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, January 1, 2014 through December 31, 2016, be regarded as expenditures under the state's Title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan Section 1115 Demonstration.

1. Premium Assistance and Cost Sharing Reduction Payments. Expenditures for part or all of the cost of assisting individuals, with incomes above 100 percent of the federal poverty line who are eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act who are neither medically frail nor have access to cost effective employer sponsored insurance (the Marketplace Choice Population), with the payment of Qualified Health Plan insurance premiums for third party individual market insurance coverage from a Qualified Health Plan through the Marketplace, and with the payment of cost sharing required under Qualified Health Plan.

Requirements Not Applicable to the Expenditure Authority:

1. Cost Effectiveness

**Section 1902(a)(4)) insofar
as it incorporates 42 CFR
435.1015(a)(4)**

To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments for the Marketplace Choice Population in the Marketplace that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

**Approval Period: January 1, 2014 through December 31, 2016
Amended December 30, 2013**

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

December 30, 2013

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from January 1, 2014 through December 31, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Iowa Marketplace Choice section 1115 demonstration.

1. Eligibility Requirements Section 1902(a)(10)(A)(i)(VIII)

To enable the state to impose, as a condition of eligibility for certain individuals eligible under section 1902(a)(10)(A)(i)(VIII) who have incomes above 100 percent of the Federal Poverty Line (FPL) and who are neither medically frail nor have access to cost-effective employer-sponsored insurance (the Marketplace Choice Plan Population), a requirement to enroll in a designated Qualified Health Plan offered through the Marketplace.

2. Premiums Section 1902(a)(14) and Section 1916

To enable the state to charge premiums in excess of applicable Medicaid limits to the Marketplace Choice population, subject to a quarterly aggregate cap of 5 percent of family income.

3. Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

To the extent necessary to relieve the state of the obligation to assure transportation to and from providers for the Marketplace Choice population. This waiver authority will expire December 31, 2014 unless an extension is otherwise approved under the requirements of paragraph 7 (Amendment Process) of the STCs.

4. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable Iowa to limit Marketplace Choice population beneficiaries' freedom of choice to a choice of providers participating in the network of the Marketplace Choice plan beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

5. Prior Authorization

Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)

To the extent necessary to permit Iowa to require that requests for prior authorization for drugs be addressed within 72 hours for the Marketplace Choice population. A requested medication will be provided to the extent necessary to address an emergency.

6. Payment to Providers

Section 1902(a)(13) and Section 1902(a)(30)

To the extent necessary to permit Iowa to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services to the Marketplace Choice population.

7. Comparability

Section 1902(a)(17)

To enable Iowa to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the state to provide reduced cost sharing for the newly eligible population. This will be done through an \$8 copay for non-emergency us of the emergency department. This copay will not apply to other Medicaid populations; copays applied to other Medicaid populations will not be imposed on this population.

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

NUMBER: 11-W00288/5

TITLE: Iowa Marketplace Choice Plan

AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority authorizing federal matching of demonstration costs no otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Marketplace Choice Plan with eligibility effective January 1, 2014. The demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Iowa Marketplace Choice Plan Enrollment
- VI. Premium Assistance Delivery System
- VII. Benefits
- VIII. Healthy Behaviors, Premiums, and Cost Sharing
- IX. Appeals
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation
- XIV. Monitoring
- XV. Health Information Technology and Premium Assistance
- XVI. T-MSIS Requirements

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

The Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, can be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.

The authority enabling the state to begin charging premiums in year 2 is subject to a quarterly aggregate cap of 5 percent of family income. We have provided authority to enable the state to not provide non-emergency medical transportation for individuals in the Marketplace Choice demonstration. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care.

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

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

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

Iowa proposes to demonstrate the following key features:

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advanced of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the

demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

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

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

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

- a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 69; and

- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

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

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

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

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

§431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.

- e. Exemption from Public Notice Procedures 42.CFR §431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report as specified in STC 44 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 46.

11. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

12. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

- c. Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

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

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

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

- a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration

proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

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

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

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

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

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

V. MARKETPLACE CHOICE PLAN PREMIUM ASSISTANCE ENROLLMENT

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

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

- a. **QHP Plan Selection.** The notice will include information regarding how Marketplace Choice plan beneficiaries can select a QHP. The state will ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan
- b. **Access to Services until QHP Enrollment is Effective.** The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.
- c. **Direct State Plan Benefits (supplementing QHP covered benefits).** The notice will also include information on how beneficiaries can use the CIN number to access direct state plan benefits. The notice will include specific information regarding services that supplement QHP benefits and are covered directly through Medicaid, what phone numbers to call or websites to visit to access direct services, and any cost-sharing for wrapped services pursuant to STC 31.
- d. **Appeals.** The notice will also include information regarding the grievance and appeals process.
- e. **Exemption from the Alternative Benefit Plan.** The notice will include information describing how Marketplace Choice plan beneficiaries who believe they may be exempt from the Marketplace Choice ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP. This notice will describe how beneficiaries seeking to participate in the Marketplace Choice premium assistance can opt out of the medical frailty screening during the QHP selection process.

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

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

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

- a. Individuals will submit a joint application for insurance affordability programs— Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions— electronically, via phone, by mail, or in-person.
- b. A Medicaid eligibility determination will be made either through the Marketplace or the Iowa Department of Human Services.
- c. Once individuals have been determined Medicaid-eligible in the new adult population, they will have an opportunity to complete the health care needs questionnaire, to be assessed for medical frailty as defined in STC 18. They will also have an opportunity to opt-out of the medical frailty assessment if they prefer to enroll in the Marketplace Choice demonstration. Individuals will be notified of the potential consequences of a medical frailty designation as part of the screen offering an opt-out.
- d. A determination of availability of cost-effective employer-sponsored insurance will be made.
- e. A determination of AI/AN status and offering option to opt in to Marketplace Choice.
- f. Individuals who are determined to be in the Marketplace Choice plan population will have an opportunity to shop among QHPs available to Marketplace Choice plan eligible individuals.
- g. The State’s MMIS will capture their plan selection information and will transmit the enrollment transactions to the QHP issuers.
- h. QHP issuers will issue insurance cards to Marketplace Choice plan enrollees.
- i. The State’s MMIS will issue payments for premiums on behalf of beneficiaries directly to the QHP issuer.
- j. State MMIS premium payments to the selected QHP issuer will continue until the individual is determined to no longer be eligible for Medicaid; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail or has access to cost effective ESI.
- k. In the event that an individual is determined eligible for coverage through the Marketplace Choice Plan, but does not select a plan, the State ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan.

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

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

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

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

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

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

- a. Marketplace Choice plan population beneficiaries will be able to choose from at least two silver plans in each rating area of the State.
- b. Marketplace Choice plan population beneficiaries will be permitted to choose among the silver plans offered to Medicaid members. All Marketplace Choice plan beneficiaries will have a choice of at least two QHPs in their geographic area.
- c. The Essential Community Provider network requirements will be applied by the state as part of the QHP certification process.
- d. Marketplace Choice plan beneficiaries will have access to the same networks as other individuals enrolling in the same silver level QHP.

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

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

VI. BENEFITS

- 30. Iowa Marketplace Choice Plan Benefits.** Individuals affected by this demonstration will receive benefits described in the Iowa Marketplace Choice alternative benefit plan.
- 31. Direct Medicaid Benefits.** The State will ensure payment under the State plan for ABP benefits that are not covered by QHPs. These benefits include Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21.
- 32. Access to Direct State Plan Benefits.** In addition to receiving an insurance card from the applicable QHP issuer, Marketplace Choice plan beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for direct state plan benefits. The notice containing the CIN will include information about which services Marketplace Choice plan beneficiaries are direct Medicaid benefits and how to access those services. This information will also be posted on Iowa Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers.
- 33. Non-Emergency Medical Transportation (NEMT).** Individuals affected by this demonstration shall not benefit from any administrative activity or service to assure non-emergency transportation to and from providers. This waiver authority will sunset after one year, to allow for reevaluation of this authority; the state and CMS will consider the impact on access to care.
- 34. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions) of the Act.
- 35. FQHC and RHC Services.** At least one QHP in each service area will contract with at least one FQHC and RHC, where FQHC or RHC services are available.

VIII. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

- 36. Premiums.**
- a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 40.
 - b. No premium will be charged for the first year of enrollment in the Iowa Marketplace Choice Plan.
 - c. All premiums in this section are subject to the exemptions and waivers described in STC 37.
 - d. Monthly premium amounts may not exceed \$10/month for nonexempt households between 100-133 percent of the FPL.
 - e. Enrollees will be allowed a 90 day premium grace period.

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

- a. For all individuals enrolled in the Iowa Marketplace Choice Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period as outlined in the Healthy Behavior Incentive Protocol once approved as Attachment A.
- b. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.
- c. All individuals who self-attest to a financial hardship will have no premium obligation. The opportunity to self-attest will be made available with each invoice.

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

39. Iowa Marketplace Choice Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in 40. Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

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

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

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

Healthy Behaviors

- i) The purpose and objectives of the Healthy Behaviors Incentive program.
- ii) The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
- iii) The criteria to be met for completing a wellness exam.
- iv) The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
- v) The positive incentives that could be used both for purposes of reducing premiums or other health-related purposes, and the amount of positive incentives that can be earned on an annual basis which should be at least as much as the annual premium contributions required.
- vi) A list of stakeholders consulted in the development of the protocol.
- vii) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
- viii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.

Premiums

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

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

- i) A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
- ii) A description of selected healthy behaviors to be met by an individual in year 2 (or subsequent years), whereas, an individual will be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 3 (or subsequent years). Iowa will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Iowa must obtain CMS approval before the state can introduce new requirements to enrollees.

- c. **Premium Monitoring Protocols.** By August 1, 2014, the state will submit for approval, criteria by which the state will monitor premiums and thresholds for modification and/or termination of premium collection in the event of unintended harm to beneficiaries. This monitoring shall include data related to premium payment/non-payment. The state shall include the data it will report to CMS in quarterly reports which must include but are not limited to the number of:
 - i) Individuals subject to premium requirements (i.e. number of nonexempt individuals),
 - ii) Individuals whose premiums have been waived due to compliance with healthy behaviors,
 - iii) Individuals exempt due to hardship.
 - iv) Individuals disenrolled due to premium non-payment.
 - v) Individuals with overdue premiums including those with premiums past due less than and greater than 90 days.
 - vi) Information about the state's collection activities.

- d. **CMS Review of the Protocols.** Once approved by CMS, the Healthy Behaviors and Premiums Protocols will become Attachment A of these STCs, and will be binding upon the state. The state may request changes to the approved Healthy Behaviors and Premiums Protocols, which must be approved by CMS, and which will be effective prospectively.

IX. APPEALS

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

X. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
- b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

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

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

- a. All items included in the quarterly report pursuant to STC 44 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

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

XI. GENERAL FINANCIAL REQUIREMENTS

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

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

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

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 60.
- b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
- c. **Premium and Cost Sharing Contributions.** To the extent Iowa collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to

demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.

- d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.
- e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “New Adult Group”
- f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

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

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

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

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

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 44, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly

report, which certifies the accuracy of this information.

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

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

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

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

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

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

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

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

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

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

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

57. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 60, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

58. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 60, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

59. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 60 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 62 below.

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

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult Group	4.7%	\$ 549.65	\$ 575.48	\$ 602.54

- a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in

paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

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

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

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

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

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

DY 3	Cumulative budget neutrality limit plus:	0%
------	--	----

64. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

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

66. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment B.

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

- a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
- b. Included in the evaluation will be examinations using a robust set of measures of consumer experience, provider access and clinical quality measures under the Marketplace Choice Plan Demonstration compared to what would have happened for a comparable population in Medicaid.
- c. The State will compare total costs under the Marketplace Choice Plan Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
- d. The State will compare changes in consumer experience, access and quality to associated changes in costs within the Marketplace Choice Plan. To the extent possible, component contributions to changes in consumer experience, access and quality and their associated

levels of investment in Iowa will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

- a. The scientific rigor of the analysis;
- b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
- c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
- d. How the analysis will support a determination of cost effectiveness;
- e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- f. The unique contributions and interactions of other initiatives; and
- g. How the evaluation and reporting will develop and be maintained.

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

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

69. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

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

- i. Premium Assistance beneficiaries will have equal or better access to care than if the population were not required to enroll in a QHP, including primary care and specialty physician networks and services.

- ii. Premium Assistance beneficiaries will have equal or better access to preventive care services than if they were not required to enroll in a QHP.
 - iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services than if they were not required to enroll in a QHP.
 - iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage when their eligibility status changes.
 - v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers, when their eligibility status changes.
 - vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs when their eligibility status changes.
 - vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions than if they were not required to enroll in a QHP.
 - viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided than if they were not required to enroll in a QHP.
 - ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have satisfactory and appropriate access to these benefits.
 - x. Premium Assistance beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
 - xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
 - xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Iowa Medicaid fee-for-service in accordance with STC 67 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
 - xiii. Premiums incentivize enrollees to complete healthy behaviors.
 - xiv. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
 - xv. Enrollees will experience greater access to dental providers.
 - xvi. The monthly premium does not pose an access to care barrier.
 - xvii. Marketplace Choice Plan enrollees will use preventative care services at a greater rate than if the demonstration were not in place.
- b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:
- i. Comparisons of provider networks;
 - ii. Consumer satisfaction and other indicators of consumer experience;
 - iii. Provider experience ; and
 - iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

- c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
- f. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
 - i. Medicaid encounter and claims data,
 - ii. Enrollment data,
 - iii. Provider Network data,
 - iv. Consumer and provider surveys, and
 - v. Other data needed to support performance measurement relative to access and quality metrics.
- g. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available, including from health plans.
- h. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall

include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

- i. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.
- j. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

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

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

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

- a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
- b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
- c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

- d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
- e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
- f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

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

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

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

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

76. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

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

78. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff,

administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

79. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

80. Evaluation Monitoring Protocol. The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the Demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.

- a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.
- b. The State shall make the necessary arrangements to assure that the data needed from the health plans to which premium assistance will apply, and data needed from other sources, are available as required by the CMS approved monitoring protocol.
- c. The monitoring protocol and reports shall be posted on the State Medicaid website within 30 days of CMS approval.

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

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

83. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by

population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

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

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

XVI. T-MSIS REQUIREMENTS

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-26-16
Baltimore, Maryland 21244-1850



Office of the Administrator

December 30, 2013

Jennifer Vermeer
Medicaid Director
State of Iowa
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Dear Ms. Vermeer:

The Centers for Medicare & Medicaid Services (CMS) is approving Iowa's request to amend its Medicaid demonstrations entitled, "Iowa Wellness Plan" (Project Number 11-W-00289/5) and "Iowa Marketplace Choice" (Project Number 11-W-00288/5), which were approved by CMS on December 10, 2013.

The CMS' approval of these demonstrations is conditioned upon compliance with the enclosed sets of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. As discussed, we have amended the Iowa Wellness Plan demonstration to permit premiums for households from 50 up to 100 percent of the Federal Poverty Level (FPL) at a nominal amount (\$5/month) which may be waived for hardship or reduced/ eliminated by completion of healthy behaviors. Authority to charge premiums is subject to the state demonstrating access to healthcare services, such that beneficiaries will be able to complete the healthy behaviors. Nonpayment of premiums for individuals in this group may not result in disenrollment. Additionally, we have amended the Marketplace Choice Plan to specify that premiums for households above 100 percent of the FPL will be \$10/month. The award is subject to our receipt of your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the updated STCs, waivers, and expenditure authorities are enclosed for your review.

Your project officer for these demonstrations is Mrs. Vanessa Sammy. She is available to answer any questions concerning your section 1115 demonstration Mrs. Sammy's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2613

E-mail: Vanessa.Sammy@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mrs. Sammy and to Mr. James Scott, Associate Regional Administrator, in our Kansas City Regional Office. Mr. Scott's contact information is as follows:

Centers for Medicare & Medicaid Services
Richard Bolling Federal Building
601 East 12th Street
Room 355
Kansas City, MO 64106-2808
Telephone: (816) 426-6417
Email: James.Scott1@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in Iowa, over the past several months on developing this important demonstration. Congratulations on this approval.

Sincerely,

/s/

Marilyn Tavenner

Enclosures

cc: James Scott, ARA, Region VII

CENTERS FOR MEDICARE AND MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, January 1, 2014 through December 31, 2016, be regarded as expenditures under the state's Title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan Section 1115 Demonstration.

1. Premium Assistance and Cost Sharing Reduction Payments. Expenditures for part or all of the cost of assisting individuals, with incomes above 100 percent of the federal poverty line who are eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act who are neither medically frail nor have access to cost effective employer sponsored insurance (the Marketplace Choice Population), with the payment of Qualified Health Plan insurance premiums for third party individual market insurance coverage from a Qualified Health Plan through the Marketplace, and with the payment of cost sharing required under Qualified Health Plan.

Requirements Not Applicable to the Expenditure Authority:

1. Cost Effectiveness

**Section 1902(a)(4)) insofar
as it incorporates 42 CFR
435.1015(a)(4)**

To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments for the Marketplace Choice Population in the Marketplace that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

**Approval Period: January 1, 2014 through December 31, 2016
Amended December 30, 2013**

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

December 30, 2013

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from January 1, 2014 through December 31, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Iowa Marketplace Choice section 1115 demonstration.

1. Eligibility Requirements Section 1902(a)(10)(A)(i)(VIII)

To enable the state to impose, as a condition of eligibility for certain individuals eligible under section 1902(a)(10)(A)(i)(VIII) who have incomes above 100 percent of the Federal Poverty Line (FPL) and who are neither medically frail nor have access to cost-effective employer-sponsored insurance (the Marketplace Choice Plan Population), a requirement to enroll in a designated Qualified Health Plan offered through the Marketplace.

2. Premiums Section 1902(a)(14) and Section 1916

To enable the state to charge premiums in excess of applicable Medicaid limits to the Marketplace Choice population, subject to a quarterly aggregate cap of 5 percent of family income.

3. Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

To the extent necessary to relieve the state of the obligation to assure transportation to and from providers for the Marketplace Choice population. This waiver authority will expire December 31, 2014 unless an extension is otherwise approved under the requirements of paragraph 7 (Amendment Process) of the STCs.

4. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable Iowa to limit Marketplace Choice population beneficiaries' freedom of choice to a choice of providers participating in the network of the Marketplace Choice plan beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

5. Prior Authorization

Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)

To the extent necessary to permit Iowa to require that requests for prior authorization for drugs be addressed within 72 hours for the Marketplace Choice population. A requested medication will be provided to the extent necessary to address an emergency.

6. Payment to Providers

Section 1902(a)(13) and Section 1902(a)(30)

To the extent necessary to permit Iowa to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services to the Marketplace Choice population.

7. Comparability

Section 1902(a)(17)

To enable Iowa to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the state to provide reduced cost sharing for the newly eligible population.

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

NUMBER: 11-W00288/5

TITLE: Iowa Marketplace Choice Plan

AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority authorizing federal matching of demonstration costs no otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Marketplace Choice Plan with eligibility effective January 1, 2014. The demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Iowa Marketplace Choice Plan Enrollment
- VI. Premium Assistance Delivery System
- VII. Benefits
- VIII. Healthy Behaviors, Premiums, and Cost Sharing
- IX. Appeals
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation
- XIV. Monitoring
- XV. Health Information Technology and Premium Assistance
- XVI. T-MSIS Requirements

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

The Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, can be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.

The authority enabling the state to begin charging premiums in year 2 is subject to a quarterly aggregate cap of 5 percent of family income. We have provided authority to enable the state to not provide non-emergency medical transportation for individuals in the Marketplace Choice demonstration. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care.

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

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

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

Iowa proposes to demonstrate the following key features:

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advanced of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the

demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

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

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

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

- a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 69; and

- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

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

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

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

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

§431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.

- e. Exemption from Public Notice Procedures 42.CFR §431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report as specified in STC 44 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 46.

11. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

12. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

- c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

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

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

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

- a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration

proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

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

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

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

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

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

V. MARKETPLACE CHOICE PLAN PREMIUM ASSISTANCE ENROLLMENT

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

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

- a. **QHP Plan Selection.** The notice will include information regarding how Marketplace Choice plan beneficiaries can select a QHP. The state will ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan
- b. **Access to Services until QHP Enrollment is Effective.** The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.
- c. **Direct State Plan Benefits (supplementing QHP covered benefits).** The notice will also include information on how beneficiaries can use the CIN number to access direct state plan benefits. The notice will include specific information regarding services that supplement QHP benefits and are covered directly through Medicaid, what phone numbers to call or websites to visit to access direct services, and any cost-sharing for wrapped services pursuant to STC 31.
- d. **Appeals.** The notice will also include information regarding the grievance and appeals process.
- e. **Exemption from the Alternative Benefit Plan.** The notice will include information describing how Marketplace Choice plan beneficiaries who believe they may be exempt from the Marketplace Choice ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP. This notice will describe how beneficiaries seeking to participate in the Marketplace Choice premium assistance can opt out of the medical frailty screening during the QHP selection process..

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

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

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

- a. Individuals will submit a joint application for insurance affordability programs— Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions— electronically, via phone, by mail, or in-person.
- b. A Medicaid eligibility determination will be made either through the Marketplace or the Iowa Department of Human Services.
- c. Once individuals have been determined Medicaid-eligible in the new adult population, they will have an opportunity to complete the health care needs questionnaire, to be assessed for medical frailty as defined in STC 18. They will also have an opportunity to opt-out of the medical frailty assessment if they prefer to enroll in the Marketplace Choice demonstration. Individuals will be notified of the potential consequences of a medical frailty designation as part of the screen offering an opt-out.
- d. A determination of availability of cost-effective employer-sponsored insurance will be made.
- e. A determination of AI/AN status and offering option to opt in to Marketplace Choice.
- f. Individuals who are determined to be in the Marketplace Choice plan population will have an opportunity to shop among QHPs available to Marketplace Choice plan eligible individuals.
- g. The State’s MMIS will capture their plan selection information and will transmit the enrollment transactions to the QHP issuers.
- h. QHP issuers will issue insurance cards to Marketplace Choice plan enrollees.
- i. The State’s MMIS will issue payments for premiums on behalf of beneficiaries directly to the QHP issuer.
- j. State MMIS premium payments to the selected QHP issuer will continue until the individual is determined to no longer be eligible for Medicaid; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail or has access to cost effective ESI.
- k. In the event that an individual is determined eligible for coverage through the Marketplace Choice Plan, but does not select a plan, the State ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan.

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

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

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

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

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

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

- a. Marketplace Choice plan population beneficiaries will be able to choose from at least two silver plans in each rating area of the State.
- b. Marketplace Choice plan population beneficiaries will be permitted to choose among the silver plans offered to Medicaid members. All Marketplace Choice plan beneficiaries will have a choice of at least two QHPs in their geographic area.
- c. The Essential Community Provider network requirements will be applied by the state as part of the QHP certification process.
- d. Marketplace Choice plan beneficiaries will have access to the same networks as other individuals enrolling in the same silver level QHP.

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

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

VI. BENEFITS

- 30. Iowa Marketplace Choice Plan Benefits.** Individuals affected by this demonstration will receive an alternative benefit plan (ABP) described in the Medicaid State plan.
- 31. Direct Medicaid Benefits.** The State will ensure payment under the State plan for ABP benefits that are not covered by QHPs. These benefits include Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21.
- 32. Access to Direct State Plan Benefits.** In addition to receiving an insurance card from the applicable QHP issuer, Marketplace Choice plan beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for direct state plan benefits. The notice containing the CIN will include information about which services Marketplace Choice plan beneficiaries are direct Medicaid benefits and how to access those services. This information will also be posted on Iowa Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers.
- 33. Non-Emergency Medical Transportation (NEMT).** Individuals affected by this demonstration shall not benefit from any administrative activity or service to assure non-emergency transportation to and from providers. This waiver authority will sunset after one year, to allow for reevaluation of this authority; the state and CMS will consider the impact on access to care.
- 34. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions) of the Act.
- 35. Access to Federally Qualified Health Centers and Rural Health Centers.** Marketplace Choice plan enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

VIII. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

36. Premiums.

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

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

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

- a. For all individuals enrolled in the Iowa Marketplace Choice Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period as outlined in the Healthy Behavior Incentive Protocol once approved as Attachment A.
- b. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.
- c. All individuals who self-attest to a financial hardship will have no premium obligation. The opportunity to self-attest will be made available with each invoice.

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

39. Iowa Marketplace Choice Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in 40. Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

- a. **General Description.** All individuals subject to premiums who are enrolled in the Iowa Marketplace Choice Plan will have premiums waived in year 1 and will be eligible to receive a waiver of monthly premium contributions required in year 2 of enrollment if enrollees complete healthy behaviors during year 1 of enrollment. For each subsequent year, nonexempt enrollees will have the opportunity to complete healthy behaviors to continue to waive financial contributions, i.e. healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.
- b. **Healthy behaviors.** The conditions to be met by a nonexempt individual in year 1 of enrollment as a condition for not being liable for monthly contributions in year 2 are completing a health risk assessment and wellness exam (annual exam). A health risk assessment is considered part of the individual's medical record and is afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy.

- c. **Grace Period.** Nonexempt individuals will be given a 30 day healthy behavior grace period. If the individual completes the required healthy behaviors in the first 30 days of year when premiums are due, no premiums will be due for the remainder of the year.

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

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

Healthy Behaviors

- i) The purpose and objectives of the Healthy Behaviors Incentive program.
- ii) The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
- iii) The criteria to be met for completing a wellness exam.
- iv) The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
- v) The positive incentives that could be used both for purposes of reducing premiums or other health-related purposes, and the amount of positive incentives that can be earned on an annual basis which should be at least as much as the annual premium contributions required.
- vi) A list of stakeholders consulted in the development of the protocol.
- vii) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
- viii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.

Premiums

- ix) The process by which the state will identify individuals who are exempt from the premium requirements
 - x) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
 - xi) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
 - xii) The process by which the state will collect past due premiums.
- b. **Future Year Healthy Behaviors Incentives Standards.** By August 1, 2014 (and succeeding years), the state will submit for approval, the protocol with the following Healthy Behaviors Incentive Program standards:
 - i) A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
 - ii) A description of selected healthy behaviors to be met by an individual in year 2 (or subsequent years), whereas, an individual will be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 3 (or subsequent

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

IX. APPEALS

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

X. GENERAL REPORTING REQUIREMENTS

- 41. General Financial Requirements.** The State must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.
- 42. Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

- 43. Monthly Monitoring Calls.** CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Marketplace Choice plan beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed include, but are not limited to:
- a. Transition and implementation activities,
 - b. Stakeholder concerns,
 - c. ACO and MCO operations and performance,
 - d. Enrollment,
 - e. Cost sharing,
 - f. Quality of care,
 - g. Access,
 - h. The benefit package,
 - i. Audits,
 - j. Lawsuits,
 - k. Financial reporting and budget neutrality issues,
 - l. Progress on evaluations,
 - m. Legislative developments, and
 - n. Any demonstration amendments the state is considering submitting.
- 44. Quarterly Progress Reports.** The state will provide quarterly reports to CMS.
- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
 - b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.
- 45. Compliance with Federal Systems Innovation.** As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.
- 46. Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.
- a. All items included in the quarterly report pursuant to STC 44 must be summarized to reflect the operation/activities throughout the DY;
 - b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and

- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

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

XI. GENERAL FINANCIAL REQUIREMENTS

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

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

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

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 60.
- b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

- c. **Premium and Cost Sharing Contributions.** To the extent Iowa collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- d. **Pharmacy Rebates.** Pharmacy rebates are not considered here as this program is not eligible.
- e. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “New Adult Group”
- f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

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

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

51. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the

operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

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

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 44, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

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

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

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

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost

sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

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

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

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

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

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

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

57. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 60, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

58. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 60, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

59. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 60 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 62 below.

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

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult Group	4.7%	\$ 549.65	\$ 575.48	\$ 602.54

- a. If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c. The State will not be allowed to obtain budget neutrality “savings” from this population.

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

62. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy

interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

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

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

64. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

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

66. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment B.

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

- a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
- b. Included in the evaluation will be examinations using a robust set of measures of consumer experience, provider access and clinical quality measures under the Marketplace Choice Plan Demonstration compared to what would have happened for a comparable population in Medicaid.
- c. The State will compare total costs under the Marketplace Choice Plan Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
- d. The State will compare changes in consumer experience, access and quality to associated changes in costs within the Marketplace Choice Plan. To the extent possible, component contributions to changes in consumer experience, access and quality and their associated levels of investment in Iowa will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

- a. The scientific rigor of the analysis;
- b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
- c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
- d. How the analysis will support a determination of cost effectiveness;
- e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- f. The unique contributions and interactions of other initiatives; and
- g. How the evaluation and reporting will develop and be maintained.

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

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

69. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

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

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

- xiv. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
 - xv. Enrollees will experience greater access to dental providers.
 - xvi. The monthly premium does not pose an access to care barrier.
 - xvii. Marketplace Choice Plan enrollees will use preventative care services at a greater rate than if the demonstration were not in place.
- b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:
- i. Comparisons of provider networks;
 - ii. Consumer satisfaction and other indicators of consumer experience;
 - iii. Provider experience ; and
 - iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.
- c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
- f. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

- i. Medicaid encounter and claims data,
 - ii. Enrollment data,
 - iii. Provider Network data,
 - iv. Consumer and provider surveys, and
 - v. Other data needed to support performance measurement relative to access and quality metrics.
- g. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available, including from health plans.
- h. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.
- i. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.
- j. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

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

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

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

- a. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
- b. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
- c. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
- d. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
- e. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
- f. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

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

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

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

- 75. Electronic Submission of Reports.** The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.
- 76. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.
- 77. Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.
- 78. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 79. Deferral for Failure to Provide Summative Evaluation Reports on Time.** The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

- 80. Evaluation Monitoring Protocol.** The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the Demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.
- a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.
 - b. The State shall make the necessary arrangements to assure that the data needed from the health plans to which premium assistance will apply, and data needed from other sources, are available as required by the CMS approved monitoring protocol.
 - c. The monitoring protocol and reports shall be posted on the State Medicaid website within 30 days of CMS approval.
- 81. Quarterly Evaluation Operations Report.** The State will provide quarterly reports to

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

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

83. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

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

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

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are

expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Iowa against which the premium assistance demonstration will be compared.

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



Administrator
Washington, DC 20201

Jennifer Vermeer
Medicaid Director
State of Iowa
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

DEC 10 2013

Dear Ms. Vermeer:

The Centers for Medicare & Medicaid Services is approving Iowa's request for two new three-year Medicaid demonstrations, "Iowa Wellness Plan", (Project Number 11-W-00289/5) and "Iowa Marketplace Choice", (Project Number 11-W-00288/5). The demonstrations are approved in accordance with section 1115(a) of the Social Security Act (the Act) and are effective as of the date of the signed approval. Through these demonstrations and associated state plan amendments, the state will ensure coverage to all adults in Iowa with incomes up to and including 133 percent of the federal poverty level (FPL). Enrollment for the new adult population began on October 1, 2013, with eligibility effective on January 1, 2014.

The CMS approval of these demonstrations is conditioned upon compliance with the enclosed sets of STCs defining the nature, character, and extent of anticipated federal involvement in the projects. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Alternatively, the state may advise CMS of any modifications it would like us to consider. A copy of the STCs, waivers, and expenditure authorities are enclosed for your review.

Marketplace Choice Demonstration

The "Iowa Marketplace Choice" demonstration provides authority to Iowa to offer certain individuals in the new adult eligibility group premium assistance to enable such individuals to purchase coverage offered by qualified health plans (QHPs) in the Marketplace. The Marketplace Choice population will consist of most non-medically frail individuals aged 19-64 with incomes above 100 percent of the FPL, except those with access to cost-effective employer sponsored insurance (and with special provisions for American Indians and Alaskan Natives to choose demonstration benefits). We have granted authority in the Marketplace Choice demonstration allowing Iowa to align Medicaid timing requirements for prior authorization for drugs with requirements applicable to QHPs. The demonstration will not affect access for beneficiaries under age 21 to early and periodic screening and diagnostic treatment (EPSDT) services, and all beneficiaries in the demonstration shall be able to access out-of-network family planning.

The Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, can be imposed in year 2 of the demonstration. Enrollees who complete all required healthy behaviors during year 1 of the demonstration shall have their premiums waived in year 2. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and will not need to make financial contributions if they do so. In other words, beneficiaries who meet healthy behaviors goals in year 2 will not pay premiums for year 3.

Premiums that the state can impose will not be more than Marketplace premiums and total cost sharing is subject to a quarterly aggregate cap of 5 percent of family income. We have provided authority to relieve the state from the responsibility to assure non-emergency medical transportation to and from providers for the Marketplace Choice population. This waiver authority will sunset after one year, to allow for the state and CMS to consider the impact on access to care. Beneficiaries' cost-sharing obligations (other than premiums) under this demonstration will be consistent with state plan requirements.

Health and Wellness Demonstration

Under the approved Health and Wellness Demonstration and associated state plan amendments, Iowa will serve individuals ages 19 through 64 with income up to and including 100 percent of the FPL in the new adult group, as well as individuals above 100 percent up to and including 133 percent of the FPL, who are medically frail, are American Indians and Alaska Natives, or have access to employer sponsored insurance. Covered services will be furnished in ways that promote coordinated care, including the use of managed care and Accountable Care Organizations (ACOs) under the state plan. The Health and Wellness Plan program will promote healthy behaviors through education and engagement of beneficiaries and providers, and includes an incentive component that is intended to promote healthy behaviors. Premiums are not authorized. Under the demonstration, the state is relieved of the responsibility to assure non-emergency medical transportation to and from the providers. This waiver authority will sunset after one year, to allow for reevaluation on access to care. Beneficiaries' cost-sharing obligations, which include copayments for non-emergency use of emergency room services, will be consistent with state plan requirements.

Your project officer for these demonstrations is Mrs. Vanessa Sammy. She is available to answer any questions concerning your section 1115 demonstration Mrs. Sammy's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-02-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2613
Facsimile: (410) 786-5882
E-mail: Vanessa.Sammy@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mrs. Sammy and to Mr. James Scott, Associate Regional Administrator in our Kansas City Regional Office. Mr. Scott's contact information is as follows:

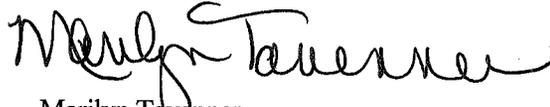
Centers for Medicare & Medicaid Services
Richard Bolling Federal Building
601 East 12th Street
Room 355
Kansas City, MO 64106-2808
Telephone: (816) 426-6417
Email: James.Scott1@cms.hhs.gov

Page 3 – Ms. Jennifer Vermeer

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in Iowa, over the past several months on developing this important demonstration, and congratulations on its approval.

Sincerely,



Marilyn Tavenner

Enclosures

cc: Cindy Mann, CMCS
Eliot Fishman, CMCS
Jennifer Ryan, CMCS
James Scott, ARA, Region VI
Diane Gerrits, CMCS
Vanessa Sammy, CMCS

CENTERS FOR MEDICARE AND MEDICAID SERVICES

EXPENDITURE AUTHORITY

December 10, 2013

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, January 1, 2014 through December 31, 2016, be regarded as expenditures under the state's Title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan Section 1115 Demonstration.

1. Premium Assistance and Cost Sharing Reduction Payments. Expenditures for part or all of the cost of assisting individuals, with incomes above 100 percent of the federal poverty line who are eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act who are neither medically frail nor have access to cost effective employer sponsored insurance (the Marketplace Choice Population), with the payment of Qualified Health Plan insurance premiums for third party individual market insurance coverage from a Qualified Health Plan through the Marketplace, and with the payment of cost sharing required under Qualified Health Plan.

Requirements Not Applicable to the Expenditure Authority:

1. Cost Effectiveness

**Section 1902(a)(4)) insofar
as it incorporates 42 CFR
435.1015(a)(4)**

To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments for the Marketplace Choice Population in the Marketplace that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Iowa Marketplace Choice Plan

Approval Period: January 1, 2014 through December 31, 2016

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

December 10, 2013

NUMBER: 11-W-00288/5

TITLE: Iowa Marketplace Choice Plan Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from January 1, 2014 through December 31, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Iowa Marketplace Choice section 1115 demonstration.

1. Eligibility Requirements Section 1902(a)(10)(A)(i)(VIII)

To enable the state to impose, as a condition of eligibility for certain individuals eligible under section 1902(a)(10)(A)(i)(VIII) who have incomes above 100 percent of the Federal Poverty Line (FPL) and who are neither medically frail nor have access to cost-effective employer-sponsored insurance (the Marketplace Choice Plan Population), a requirement to enroll in a designated Qualified Health Plan offered through the Marketplace.

2. Premiums Section 1902(a)(14) and Section 1916

To enable the state to charge premiums in excess of applicable Medicaid limits to the Marketplace Choice population, subject to a quarterly aggregate cap of 5 percent of family income.

3. Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

To the extent necessary to relieve the state of the obligation to assure transportation to and from providers for the Marketplace Choice population. This waiver authority will expire December 31, 2014 unless an extension is otherwise approved under the requirements of paragraph 7 (Amendment Process) of the STCs.

4. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable Iowa to limit Marketplace Choice population beneficiaries' freedom of choice to a choice of providers participating in the network of the Marketplace Choice plan beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

5. Prior Authorization

Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)

To the extent necessary to permit Iowa to require that requests for prior authorization for drugs be addressed within 72 hours for the Marketplace Choice population. A requested medication will be provided to the extent necessary to address an emergency.

6. Payment to Providers

Section 1902(a)(13) and Section 1902(a)(30)

To the extent necessary to permit Iowa to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services to the Marketplace Choice population.

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

NUMBER: 11-W00288/5

TITLE: Iowa Marketplace Choice Plan

AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority authorizing federal matching of demonstration costs no otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Marketplace Choice Plan with eligibility effective January 1, 2014. The demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Iowa Marketplace Choice Plan Enrollment
- VI. Premium Assistance Delivery System
- VII. Benefits
- VIII. Healthy Behaviors, Premiums, and Cost Sharing
- IX. Appeals
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation
- XIV. Monitoring
- XV. Health Information Technology and Premium Assistance
- XVI. T-MSIS Requirements

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

The Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, can be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.

The authority enabling the state to begin charging premiums in year 2 is subject to a quarterly aggregate cap of 5 percent of family income. We have provided authority to enable the state to not provide non-emergency medical transportation for individuals in the Marketplace Choice demonstration. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care.

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

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

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

Iowa proposes to demonstrate the following key features:

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advanced of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the

demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

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

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

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

- a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 68; and

- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

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

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

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

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

§431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.

- e. Exemption from Public Notice Procedures 42.CFR §431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

- 10. Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report as specified in STC 46 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 48.
- 11. Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.
- 12. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
 - a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
 - b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

- c. Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

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

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

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

- a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration

proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

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

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

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

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

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

V. MARKETPLACE CHOICE PLAN PREMIUM ASSISTANCE ENROLLMENT

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

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

- a. **QHP Plan Selection.** The notice will include information regarding how Marketplace Choice plan beneficiaries can select a QHP. The state will ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan
- b. **Access to Services until QHP Enrollment is Effective.** The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.
- c. **Direct State Plan Benefits (supplementing QHP covered benefits).** The notice will also include information on how beneficiaries can use the CIN number to access direct state plan benefits. The notice will include specific information regarding services that supplement QHP benefits and are covered directly through Medicaid, what phone numbers to call or websites to visit to access direct services, and any cost-sharing for wrapped services pursuant to STC 32.
- d. **Appeals.** The notice will also include information regarding the grievance and appeals process.
- e. **Exemption from the Alternative Benefit Plan.** The notice will include information describing how Marketplace Choice plan beneficiaries who believe they may be exempt from the Marketplace Choice ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP. This notice will describe how beneficiaries seeking to participate in the Marketplace Choice premium assistance can opt out of the medical frailty screening during the QHP selection process on the State's web portal.

22. QHP Selection. The QHP in which Marketplace Choice plan population beneficiaries will enroll will be certified through the Iowa Insurance Division's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

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

- a. Individuals will submit a joint application for insurance affordability programs— Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions— electronically, via phone, by mail, or in-person.
- b. A Medicaid eligibility determination will be made either through the Marketplace or the Medicaid Enterprise.
- c. Once individuals have been determined Medicaid-eligible in the new adult population, they will have an opportunity to complete the health care needs questionnaire through the State's web-based portal, to be assessed for medical frailty as defined in STC 18. They will also have an opportunity to opt-out of the medical frailty assessment if they prefer to enroll in the Marketplace Choice demonstration. The portal will explain the potential consequences of a medical frailty designation as part of the screen offering an opt-out.
- d. A determination of availability of cost-effective employer-sponsored insurance will be made.
- e. A determination of AI/AN status and offering option to opt in to Marketplace Choice.
- f. Individuals who are determined to be in the Marketplace Choice plan population will have an opportunity to shop among QHPs available to Marketplace Choice plan eligible individuals through the State's web-based portal and to select a QHP.
- g. The State's MMIS will capture their plan selection information and will transmit the enrollment transactions to the QHP issuers.
- h. QHP issuers will issue insurance cards to Marketplace Choice plan enrollees.
- i. The State's MMIS will issue payments for premiums on behalf of beneficiaries directly to the QHP issuer.
- j. State MMIS premium payments to the selected QHP issuer will continue until the individual is determined to no longer be eligible for Medicaid; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail or has access to cost effective ESI.

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

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

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

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

- a. Enrollment of individuals in populations covered by the Demonstration;
- b. Methods for payment of premiums and cost-sharing amounts on behalf of beneficiaries;
- c. Reporting and data requirements necessary to monitor and evaluate the Marketplace Choice plan including those referenced in STC 70, ensuring enrollee access to EPSDT and other covered benefits through the QHP;
- d. Noticing requirements; and audit rights.

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

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

- a. Marketplace Choice plan population beneficiaries will be able to choose from at least two silver plans in each rating area of the State.
- b. Marketplace Choice plan population beneficiaries will be permitted to choose among all silver plans offered in their geographic area, and thus all Marketplace Choice plan beneficiaries will have a choice of at least two QHPs.
- c. The Essential Community Provider network requirements will be applied by the state as part of the QHP certification process.
- d. Marketplace Choice plan beneficiaries will have access to the same networks as other individuals enrolling in the same silver level QHP.

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

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

VII. BENEFITS

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

31. [Reserved]

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

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

34. Non-Emergency Medical Transportation (NEMT). The state is not required to assure NEMT to and from providers for the Marketplace Choice Plan population. This waiver authority will sunset after one year, to allow for reevaluation of this authority to allow for the state and CMS to consider the impact on access to care.

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

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

VIII. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

37. Healthy Behaviors and Premiums Monitoring Protocol. The Healthy Behaviors Strategies described in this section shall apply to the extent that the state establishes a protocol and documents through data and ongoing monitoring that enrollees have access to providers. .

- a. Year 1 Healthy Behaviors Incentives Standards. By March 31, 2014, the state shall submit for approval a draft section of the protocol related to year 1 Healthy Behavior Incentives including, at a minimum, the following:
 - i) The purpose and objectives of the Healthy Behaviors Incentive program.
 - ii) The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
 - iii) The criteria to be met for completing a wellness exam.
 - iv) The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
 - v) The positive incentives that could be used both for purposes of reducing premiums or other health-related purposes, and the amount of positive incentives that can be earned on an annual basis which should be at least as much as the annual premium contributions required.
 - vi) A list of stakeholders utilized in the development of the protocol.
 - vii) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
 - viii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.
- b. Year 2 Healthy Behaviors Incentives Standards. By August 1, 2014, the state will update and submit for approval, the protocol with the following Healthy Behaviors Incentive Program standards:
 - i) A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
 - ii) A description of selected healthy behaviors to be met by an individual in year 2, whereas, an individual will be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 3. Iowa will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Iowa must obtain CMS approval before the state can introduce new requirements to enrollees.
 - iii) Any access data standards and an updated monitoring protocol related to healthy behaviors to be met in year 2 not already described in Attachment A.
- c. Premium Monitoring Standards. By August 1, 2014 the state will update the protocol and submit for approval, criteria by which the state will monitor premiums and standards it will maintain while premiums are in place. This monitoring shall include data related to premium payment/non-payment and includes member surveys to identify the reasons individuals disenroll as a result of non-payment of premiums. The state shall include the data it will report to CMS in quarterly reports which must include but not limited to the number of:
 - i) Individuals subject to premium requirements,
 - ii) Number of hardship waivers requested, and
 - iii) Baseline and year 1 data regarding access and utilization.
- e. CMS Review of the Protocol. The first premium notices to enrollees must be provided no later than October 1, 2014. Once approved by CMS, the Healthy Behaviors and Premiums monitoring protocol will become Attachment A of these STCs, and will be

binding upon the state. The state may request changes to the approved Healthy Behaviors and Premiums Protocol, which must be approved by CMS, and which will be effective prospectively.

38. Premiums.

- a. All individuals are waived from the premium requirement in their first year of enrollment in the Marketplace Choice Plan.
- b. In any year an individual is subject to premiums, enrollee premiums cannot exceed two percent of household income. This level of contribution should ensure that enrollees could make their monthly contribution amounts without reaching their five percent out-of-pocket maximum limits.
- c. Enrollees will be allowed a 90 day premium grace period. The enrollee may not be disenrolled for failure to pay a premium until 90 days after a premium was due.

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

- a. For all individuals enrolled in the Marketplace Choice Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period as outlined in the Healthy Behavior Incentive Protocol once approved as Attachment A.
- b. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.
- c. The state shall grant hardship waivers for any member who self-attests to a financial hardship and the opportunity to self-attest will be made available with each invoice.

40. Iowa Marketplace Choice Plan Healthy Behaviors. Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

- a. **General Description.** All individuals enrolled in the Iowa Marketplace Choice Plan will have premiums waived in year 1 and eligible to receive a waiver of monthly premium contributions required in year 2 of enrollment if enrollees complete healthy behaviors during year 1 of enrollment. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors to continue to waive financial contributions, i.e. healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.
- b. **Healthy behaviors.** The conditions to be met by an individual in year 1 of enrollment as a condition for not being liable for monthly contributions in year 2 are completing a health risk assessment and wellness exam (annual exam). A health risk assessment is considered part of the individual's medical record and is afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy.

- c. **Grace Period.** Individuals will be given a 30 day healthy behavior grace period. If the individual completes the required healthy behaviors in the first 30 days of year when premiums are due, no premiums will be due for the remainder of the year.
- d. **Healthy Behaviors and Premiums Protocol.** The state shall not implement the Healthy Behaviors Incentives program before receiving approval from CMS for the Healthy Behaviors and Premiums protocol pertaining to the program. The state must submit a draft of the protocol to CMS for approval in accordance with STC #37.

41. Copayment for non-emergency use of the emergency department. Premiums shall be in lieu of other cost sharing except that the state may impose a copayment for non-emergency use of the emergency room consistent with its approved state plan.

42. Cost sharing. Cost sharing for Marketplace Choice plan enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR § 447.56.

IX. APPEALS

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

X. GENERAL REPORTING REQUIREMENTS

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

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

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

- a. Transition and implementation activities,
- b. Stakeholder concerns,
- c. ACO and MCO operations and performance,
- d. Enrollment,
- e. Cost sharing,

- f. Quality of care,
- g. Access,
- h. The benefit package,
- i. Audits,
- j. Lawsuits,
- k. Financial reporting and budget neutrality issues,
- l. Progress on evaluations,
- m. Legislative developments, and
- n. Any demonstration amendments the state is considering submitting.

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

- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
- b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

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

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

- a. All items included in the quarterly report pursuant to STC 46 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

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

XI. GENERAL FINANCIAL REQUIREMENTS

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

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

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

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 62.
- b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
- c. **Premium and Cost Sharing Contributions.** To the extent Iowa collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the

demonstration’s actual expenditures on a quarterly basis.

- d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.
- e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “New Adult Group”
- f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

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

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

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

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

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

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

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

56. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 63:

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

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

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall

be addressed within the time frames set by CMS.

- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

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

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

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

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

59. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 62, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS’ assessment of the State’s compliance with these annual limits will be done using the Schedule C report from the CMS-64.

60. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 62, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

61. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 62 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 63 below.

62. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 65. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult Group	4.7%	\$ 549.65	\$ 575.48	\$ 602.54

- a. If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult

group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

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

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

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

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

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

	neutrality limit plus:	
--	------------------------	--

66. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

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

68. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment B.

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

- a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
- b. Included in the evaluation will be examinations using a robust set of measures of consumer experience, provider access and clinical quality measures under the Marketplace Choice Plan Demonstration compared to what would have happened for a comparable population in Medicaid.
- c. The State will compare total costs under the Marketplace Choice Plan Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

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

69. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

- a. The scientific rigor of the analysis;
- b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
- c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
- d. How the analysis will support a determination of cost effectiveness;
- e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- f. The unique contributions and interactions of other initiatives; and
- g. How the evaluation and reporting will develop and be maintained.

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

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

70. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

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

- i. Premium Assistance beneficiaries will have equal or better access to care than if the population were not required to enroll in a QHP, including primary care and specialty physician networks and services.
 - ii. Premium Assistance beneficiaries will have equal or better access to preventive care services than if they were not required to enroll in a QHP.
 - iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services than if they were not required to enroll in a QHP.
 - iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage when their eligibility status changes.
 - v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers, when their eligibility status changes.
 - vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs when their eligibility status changes.
 - vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions than if they were not required to enroll in a QHP.
 - viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided than if they were not required to enroll in a QHP.
 - ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have satisfactory and appropriate access to these benefits.
 - x. Premium Assistance beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
 - xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
 - xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Iowa Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
 - xiii. Premiums incentivize enrollees to complete healthy behaviors.
 - xiv. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
 - xv. Enrollees will experience greater access to dental providers.
 - xvi. The monthly premium does not pose an access to care barrier.
 - xvii. Marketplace Choice Plan enrollees will use preventative care services at a greater rate than if the demonstration were not in place.
- b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:
- i. Comparisons of provider networks;
 - ii. Consumer satisfaction and other indicators of consumer experience;
 - iii. Provider experience ; and

- iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.
- c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
- f. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
 - i. Medicaid encounter and claims data,
 - ii. Enrollment data,
 - iii. Provider Network data,
 - iv. Consumer and provider surveys, and
 - v. Other data needed to support performance measurement relative to access and quality metrics.
- g. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available, including from health plans.
- h. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the

Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

- i. **Timeline:** This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.
- j. **Evaluator:** This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

71. Interim Evaluation Report. The State is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 73 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

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

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

- a. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
- b. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
- c. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or

adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

- d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
- e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
- f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

74. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 70. The State will present on its interim evaluation in conjunction with STC 71. The State will present on its summative evaluation in conjunction with STC 72.

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

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

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

77. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

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

79. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

80. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

81. Evaluation Monitoring Protocol. The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the Demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.

- a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.
- b. The State shall make the necessary arrangements to assure that the data needed from the health plans to which premium assistance will apply, and data needed from other sources, are available as required by the CMS approved monitoring protocol.
- c. The monitoring protocol and reports shall be posted on the State Medicaid website within 30 days of CMS approval.

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

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

85. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

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

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

XVI. T-MSIS REQUIREMENTS

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

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



TERRY E. BRANSTAD
GOVERNOR

August 23, 2013

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

The Honorable Barack Obama
President of the United States
1600 Pennsylvania Avenue
Washington, D.C. 20500

The Honorable Kathleen Sebelius
Secretary, U.S. Dept. of Health & Human Services (HHS)
200 Independence Avenue, SW
Washington, D.C. 20201

Dear President Obama and Secretary Sebelius:

This letter accompanies the Iowa Health and Wellness Plan (IHWP) waiver submission. We write to request expedited approval. Our plan passed with bi-partisan support and is designed to increase access, drive personal health ownership, and reform our health care delivery system to pay for quality, not quantity of health care delivered. It is an Iowa-based solution for health care in our state and demonstrates the opportunity for state flexibility in implementing health care reform. The bipartisan legislation, which passed the Democrat-controlled Iowa Senate and the Republican-controlled Iowa House, is a great example of people with different perspectives working together toward a common end. While we have varying opinions regarding the Affordable Care Act (ACA), we have not let our differences prevent us from meeting our responsibilities and moving Iowa forward.

We want to commend HHS for their work with us thus far on the IHWP. Iowa seeks 1115 waivers which allow states flexibility to test new or existing approaches to financing and delivering Medicaid. The IHWP provides access to high-quality modern health care coverage for Iowans from 0 to 138 percent of the federal poverty level (FPL). Iowans at, or below, the poverty level will have benefits like those received by state employees delivered through Accountable Care Organizations (ACOs) being developed statewide. Iowans above the poverty level will select a private insurance option from the health benefits exchange. Premium contributions, instead of traditional Medicaid co-pays, played a key role in the bipartisan compromise. Many individuals involved in the bipartisan compromise felt strongly that these premiums can help drive personal awareness and ownership of health outcomes. These contributions are intended to encourage, through positive rewards, improved access to quality care. The individual premiums were an important component of reaching a bipartisan compromise and we believe it can be an important tool in driving personal health ownership. In short, the premium component was clearly outlined in our State law and must be part of the waiver approval for the IHWP to move forward.

The IHWP does not call for all members to pay premiums. Members from 50 percent FPL and above will be asked to contribute a modest amount towards the premium cost of their care, in lieu of co-pays. These contributions are intended to encourage healthy behaviors through positive rewards and improved access to quality care. It is important to note, premiums have all been waived in the first year of the IHWP and are not due until the second year of implementation. A member must only see their primary care provider for a physical and health risk assessment and their second year premiums are

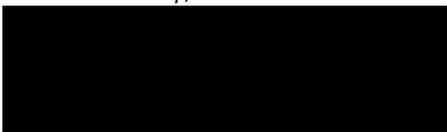
waived. This simple, but common sense approach encourages lowans to access health care in a manner that benefits their health and the long-term health of the IHWP. Previously, premium contributions were part of the Iowa Care program and did not serve as a limitation to access. Furthermore, our previous experience with premium contributions gives Iowa an ability to be prepared to implement premiums in year two. Iowa stands ready to implement our innovative approach to incentivizing individual investment in health outcomes.

Iowa has taken a practical approach to ACA implementation. Our state has reviewed and approved all submitted insurance plans for our state-federal partnership exchange model and we are working to educate consumers in Iowa about their health care options. We have leveraged the ACA innovation grant to help modernize our traditional Medicaid program. We have also raised local concerns in a thoughtful way and worked with HHS officials to find solutions for issues related to the Delta Dental and the Farm Bureau Association plans. The IHWP is another example of our practical and pragmatic path. In Iowa, Republicans and Democrats came to the table and forged an Iowa-based bipartisan compromise that respected each side's principles and priorities.

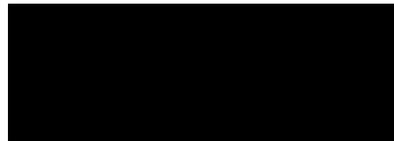
The successful implementation of the IHWP is now in your hands. We want to be innovative and implement a program that improves the health of lowans. We have been encouraged by our success in working with HHS, but our current Iowa Care waiver expires at the end of this year. Replacing the expiring Iowa Care program with the modern Iowa Health and Wellness Plan is of paramount importance to our state and our citizens. Any delays in approval may severely disrupt the coverage of many lowans. We hope that you and your team will grant an expedited approval of our waiver requests so we can move forward on our bipartisan plan to improve health outcomes in a way that works for the State of Iowa.

We will be in Washington, D.C. on September 24 and 25 and we would like to request an opportunity to meet with you both for a discussion on our innovative approach. If those dates are not convenient, we would be willing to schedule a phone call at a more convenient time in the near future. Thank you for your time and consideration.

Sincerely,



Terry E. Branstad
Governor of Iowa



Kim Reynolds
Lt. Governor of Iowa

Iowa Department of Human Services



Iowa Marketplace Choice Plan 1115 Waiver Application

August 2013

Contents

Introduction 3

Program Description and Objectives..... 5

Eligibility..... 6

 Marketplace Choice Plan Population 7

Enrollment..... 8

 Screening for Medical Frailty 12

 Screening for Employer Sponsored Insurance (ESI)..... 13

 Future Medicaid Enrollment..... 13

 Current IowaCare Members 14

 Expected Enrollment..... 14

Benefits..... 14

Delivery System..... 20

Waiver and Expenditure Authority 22

Submission of Medicaid State Plan Amendments (SPAs)..... 26

Payment of Premiums..... 26

Cost Sharing..... 26

Evaluation 29

Budget Neutrality 39

Public Notice & Transparency 39

Summary of Public Comment..... 39

Response to Comments..... 42

Appendix 1: Notice of Public Hearing 44

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 FPL¹. 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 through 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 HIPPP 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	<i>101 percent of the FPL to 133 percent of the of the FPL</i>	19 through 64	<i>Medically Frail, 42 CFR 440.315(f) Those eligible for cost-effective ESI.</i>

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.

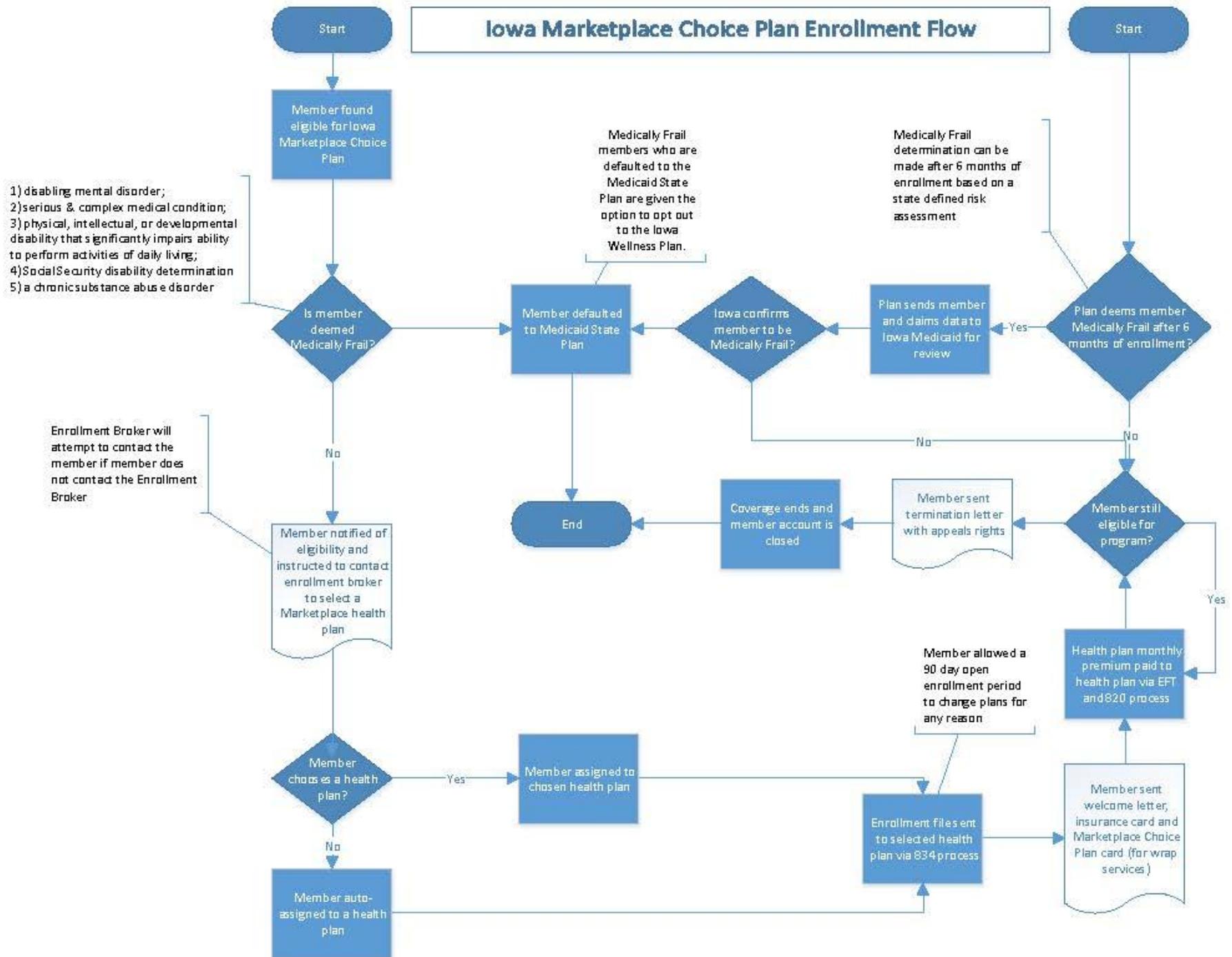
Enrollment

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.



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 Indian 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 Choice 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 1 st 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 level⁷ 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.	<p>Compare extent and comprehensiveness of traditional Medicaid and Marketplace Choice Provider Networks for primary and specialty care by geography and region.</p> <p>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.</p> <p>Compare quality and outcome metrics</p>	Traditional Medicaid Members	<p>Comparative map of network comprehensiveness</p> <p>Percent of the of members who report having a primary care physician</p> <p>Percent of the of members who report they get care quickly when needed</p> <p>Outcome and Quality Metrics including: asthma hospital readmissions, diabetes related amputation, provision of appropriate care regimens, etc.</p>	<p>QHP provider network data</p> <p>Medicaid State Plan provider network data</p> <p>Medical Expenditure Panel Survey from AHRQ (MEPS)</p> <p>NCQA HEDIS</p> <p>CAHPS</p> <p>QHP enrollee satisfaction data</p> <p>Marketplace Choice Survey</p>
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	<p>Percent of the of members receiving preventive dental care</p> <p>Percent of the</p>	<p>Claims data</p> <p>Marketplace Choice survey</p>

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

#	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.	<p>Compare access to FQHC and Family Planning Providers.</p> <p>Compare quality/outcome for Marketplace Choice and Traditional Medicaid.</p>	<p>Traditional Medicaid</p> <p>Iowa Wellness Plan</p>	<p>Percent of the members reporting difficulty accessing FQHC and Family Planning Provider</p> <p>Rate of members in comparison groups accessing these providers.</p> <p>Quality metrics such as adherence to treatment, asthma hospital readmissions, etc.</p>	<p>Claims data</p> <p>Marketplace Choice survey</p>
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.	<p>Conduct a survey of Marketplace Choice Plan members to determine if members experience barriers to access due to elimination of non-emergency transportation services.</p> <p>Review member's ability to access care in comparison with traditional Medicaid members.</p> <p>Compare member's use of emergency transportation,</p>	Traditional Medicaid population	<p>Enrollee report of access issues through enrollee survey.</p> <p>Access to care metrics including use of emergency transportation, adherence to appointments, number of</p>	<p>Marketplace Choice Plan Survey</p> <p>Claims data</p>

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

#	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.	<p>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.</p> <ul style="list-style-type: none"> Survey members that are subject to the required financial contribution to determine if the amount of financial contribution is reasonable for members. <p>Analyze experience of Marketplace Choice Plan members that do not pay within the 60-day grace period and are disenrolled.</p> <ul style="list-style-type: none"> What percent of the members reenroll? Survey disenrolled members to determine reason for disenrollment. <p>Analyze the percent of Marketplace Choice Plan members who are subject to the financial contribution</p>	<p>Marketplace Choice Plan members not subject to \$20 payment.</p> <p>Marketplace Choice Plan Members not disenrolled.</p> <p>Marketplace Choice Members that request a hardship exemption.</p> <p>Traditional Medicaid</p>	<p>Enrollee knowledge of the program</p> <p>Enrollee report on if the financial contribution is 'too low, just right, too high'</p> <p>Enrollee report on reason for disenrollment</p> <p>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.</p>	<p>Marketplace Choice Enrollee Survey</p> <p>Enrollment data</p>

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			<p>in year 2 that receive preventive services in that year.</p> <ul style="list-style-type: none"> Survey members to determine if being subject to required contribution impacted their decision making around seeking preventive care <p>Analyze the Marketplace Choice Plan members who are subject to the \$20 contribution but request a hardship waiver.</p> <ul style="list-style-type: none"> 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? <p>Examine access and quality of care for members subject to and not subject to required contributions</p>			
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.	<p>Survey marketplace choice members on non-emergency use of the emergency department and determine the impact of the \$10 required copayment.</p> <p>Compare impact of \$10 copayment for non-emergency use of the emergency department, to other programs with lesser copayment</p>	<p>Traditional Medicaid</p> <p>Other State's Medicaid Populations</p>	<p>Member response to whether copayment impacted decision making on emergency department use</p> <p>Member response on if copayment</p>	<p>Marketplace Choice Plan Member Survey</p> <p>Hospital emergency department use data</p>

#	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 <i>Potential: Other State Expansion Data on Preventive Care Utilization</i>
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. <ul style="list-style-type: none"> 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.	<p>Analysis of DSH payments</p> <p>Monitor and analyze change in commercial market premium rates in relation to change in uncompensated and under compensated care.</p> <p>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.</p>	<p>IowaCare Population</p> <p>Non-premium Assistance State Marketplace Rates</p>	<p>Change over time in percent of uncompensated care</p> <p>Change over time in percent of undercompensated care</p> <p>Change overtime in cost-shifting evaluated by age and health status adjusted commercial market rates.</p>	<p>DSH data</p> <p>Premium rate data over time</p> <p>IowaCare population utilization</p> <p>Hospital Uncompensated Care Report</p>
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	<p>Diabetes related amputations</p> <p>Asthma Hospital Readmissions</p>	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	<p>Rate of emergency department use</p> <p>Percent of individuals that report emergency department as usual source of care</p>	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	<p>SIM Quality Metrics to include:</p> <ul style="list-style-type: none"> Attributed participant experience Primary and secondary prevention Tertiary prevention Population health status Continuity of care Chronic and follow-up care 	<ul style="list-style-type: none"> 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 dietitians. 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 from 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

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% of the federal poverty level (FPL) and who are not eligible for Medicare or comprehensive Medicaid under existing Iowa Medicaid. Coverage under the Iowa Health and Wellness Plan will be provided through premium assistance for Iowa's health insurance marketplace (Marketplace) qualified health plans (QHPs), premium assistance for cost-effective employer sponsored insurance (ESI) health plans, and a new program that leverages the State Innovation Models Accountable Care Organization (ACO) demonstration and other care coordination models including Primary Care Physician (PCP) gate keepers and managed care plans to promote delivery system innovation and reform.

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.

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

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

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

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:

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

- 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.

Marketplace Choice Plan 1115 WAIVER APPLICATION August 2013

- 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.



One Financial Plaza
500 North Broadway, Suite 1750
St. Louis, MO 63102
Tel +1 314 231.3031
Fax +1 314 231.0249
www.milliman.com

August 13, 2013

Iowa Department of Human Services
Bureau of Managed Care and Clinical Services
Attention: Jennifer Vermeer
100 Army Post Road
Des Moines, IA 50315

RE: Iowa Marketplace Choice Plan 1115 Waiver Application Budget Neutrality - DRAFT

Dear Ms. Vermeer:

Milliman, Inc. (Milliman) was retained by the State of Iowa, Department of Human Services (DHS) to assist in the development of the 1115 waiver filing associated with the Iowa Marketplace Choice Plan. The Iowa Marketplace Choice Plan 1115 waiver request in concert with the Iowa Wellness Plan 1115 waiver request replace the Iowa Care 1115 waiver demonstration which expires December 31, 2013. DHS is planning to submit a five-year waiver request effective January 1, 2014. The initial waiver request aims to fill the coverage gap in the post 2014 healthcare environment by extending coverage to non-pregnant, non-medically frail individuals between 19 and 64 years of age who are between 101% and 133%¹ of the federal poverty level (FPL) based on Modified Adjusted Gross Income (MAGI) and not currently eligible for comprehensive Medicaid or Medicare coverage. Milliman was requested to prepare the budget neutrality filing materials associated with the waiver renewal filing.

LIMITATIONS

The information contained in this letter and the attached model has been prepared for the State of Iowa, Department of Human Services (DHS), to assist with submitting financial information associated with the 1115 Iowa Marketplace Choice Plan waiver to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose. The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

¹ With the 5% of FPL disregard, individual up to 138% of FPL may be eligible

Milliman

Offices in Principal Cities Worldwide

Confidential Draft – For Discussion Purposes Only. This draft is intended for discussion purposes only.

It should not be distributed to any third party, or published in whole or in part in any form, without prior written consent.



Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Iowa, Department of Human Services and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions used in this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from projected experience.

The services provided for this project were performed under the signed contract (MED-07-028) between Milliman and DHS, which was most recently extended on May 13, 2013.

EXECUTIVE SUMMARY

The State of Iowa is filing two new waiver requests to replace the Iowa Care 1115 waiver demonstration that ends on December 31, 2013. The waiver requests are for the maximum allowable time of five years (2014-2018).

The waiver period corresponds with the availability of advance premium tax credits (APTC) authorized by the Patient Protection and Affordable Care Act (ACA beginning January 1, 2014). The waiver will fill in the coverage gap for non-medically frail Iowans between 19 and 64, with income from 101% up to and including 133% of FPL, who do not currently qualify for Medicaid or Medicare. The individuals potentially eligible for the Iowa Marketplace Choice Plan have two potential coverage options:

1. Premium Assistance of Employer Sponsored Insurance (ESI) Health Plans – For individuals with access to ESI, the State will determine if the ESI is cost-effective. Premium assistance will be provided for individuals with access to cost-effective ESI under the state's existing Health Insurance Premium Payment (HIPP) program.
2. Premium Assistance for Exchange Plans – For individuals between 101% and 133% of FPL, without access to cost-effective ESI coverage, the Iowa Health and Wellness waiver will leverage the private market by providing premium assistance for plans offered through Exchanges or Marketplaces.

For each Demonstration Year (DY), the following table illustrates the total “With Waiver” amounts.

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin
2014	1	N/A	\$ 137,433,736	N/A
2015	2	N/A	\$ 204,660,842	N/A
2016	3	N/A	\$ 212,798,756	N/A
2017	4	N/A	\$ 221,259,419	N/A
2018	5	N/A	\$ 230,054,896	N/A
2014-2018	DY 1-5	N/A	\$ 1,006,207,648	N/A

Provided with this letter is the Excel file version of the waiver Cost Effectiveness materials.

The following outlines the key assumptions and development associated with the waiver cost effectiveness filing.

1. **Baseline Budget Neutrality Model.** We have utilized the budget neutrality model Excel workbook provided by CMS for Milliman’s work with another state. We have updated and revised the model for the Iowa Marketplace Choice Plan.
2. **Enrollment.** The Iowa Marketplace Choice Plan is targeted at the Adult Group, those non-medically frail individuals² who are between 19 and 64 years of age and currently not eligible for comprehensive Medicaid under an existing Iowa Medicaid group, who are not eligible for Medicare and who have income from 101% to 133% of FPL based on MAGI. The Adult Group consists of:
 - a. Iowa Care members with incomes from 101% to 133% of FPL
 - b. Currently uninsured individuals with incomes from 101% to 133% of FPL
 - c. Individuals without access to cost effective employer sponsored insurance and incomes from 101% to 133% of FPL
 - d. Individuals from 101% to 133% of FPL that drop individual health coverage (Crowd Out)
 - e. Individuals with incomes from 101% to 133% of FPL currently enrolled in Iowa’s state funded Dependent Persons Program
3. **Historical Enrollment.**
 - a. Iowa Care 101% to 133% of FPL. The Iowa Care enrollment was summarized from the state’s eligibility file for each calendar year. Only those with income between 101% and 133% of FPL were included.

² Individuals meeting the medically frail requirements (defined at 42 CFE 440.315(f)) will be given a choice of enrolling in Medicaid State Plan coverage, or the coverage option described above which they qualify for.



- b. Dependent Persons from 101% to 133% of FPL. The enrollment was summarized from the state's eligibility file. Only those with income between 101% and 133% of FPL were included.

4. Projected Enrollment.

It is estimated that all of the individuals currently enrolled in the IowaCare program at incomes from 101% up to and including 133% of FPL will enroll in the Iowa Marketplace Choice Plan demonstration unless they are medically frail; their take-up rate will be 100% as of 2014. IowaCare enrollees will be transitioned to the new program and outreach will be conducted to explain the new program components. Enrollment of the eligible population from 101% to 133% of poverty level that is not currently enrolled in IowaCare is expected to ramp up over two years with 60% of the potential enrollees joining in the first year and 30% joining in the second year; it is estimated that 10% of those potentially eligible for the Iowa Marketplace Choice Plan demonstration will choose not to enroll. For years 2015 through 2018, enrollment is projected to additionally increase at a natural growth rate of 1.5%.

Estimated enrollment in the Marketplace Choice Plan assumes that for the population with incomes from 101% FPL up to and including 133% FPL, 50% of the IowaCare population and 14% of other eligible populations will be determined to be medically frail. All individuals determined to be medically frail will be enrolled in Iowa's Wellness Plan and will not be eligible for the Iowa Marketplace Choice Plan. 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 Market Place Choice Plan, this table also provides estimates for the individuals with incomes from 101% FPL up to and including 133% FPL that will become eligible for the HIPP program due to the implementation of Iowa Health and Wellness Plan.

5. Historical Costs.

- a. Iowa Care 101% to 133% of FPL. Historical Iowa Care costs were based on claim files for each of the calendar years. Iowa Care is a limited benefit program. Estimated administrative costs were added.
- b. Dependent Persons 101% to 133% of FPL. Historical costs were based on claim files for each of the calendar years. Estimated administrative costs were added.

6. Projected Costs – Without Waiver.

Projected without waiver cost are not available nor applicable for this population under the Marketplace Choice Plan which is consistent with existing CMS guidance on.

7. Projected Costs and Value– With Waiver.

Milliman

Offices in Principal Cities Worldwide

The Iowa Marketplace Choice Plan demonstration utilizes the Secretary Approved 1937 coverage option for individuals at 101% to 133% of FPL without cost-effective ESI coverage. Individuals from 101% to 133% of FPL without cost-effective ESI coverage will have access to the State's commercial essential health benefit package through the Exchange or Marketplace plans. As required at 42 CFR 440.315(f), individuals identified as medically frail will be enrolled in the Iowa Wellness Plan where they will be defaulted to State Plan coverage but have the option to opt out and elect the alternative benefit plan coverage.

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 are being requested to standardize the benefit package for enrollees. Dental benefits will be offered through the Exchange or Marketplace, ESI plans, or, if not available, through a plan negotiated by the State.

For individuals with access to cost-effective ESI, the individual will be eligible to have their portion of premiums paid by the existing HIPP.

Individuals between 101 and 133% of FPL that do not have access to cost-effective ESI coverage will be eligible to select a health plan from the Exchange or Marketplace. This would be a commercial market qualified health plan offering the commercial essential health benefit package.

The State will make capitated payments to the Exchange or Marketplace health plans and ESI health plans.

Projected "With Waiver" costs are based on the anticipated cost, of insurance in Iowa Marketplace

The innovations in the Marketplace Choice Plan include participant wellness incentives and the utilization of private health care coverage options.

The provision of premium assistance for the Marketplace Choice Plans is cost-effective, improves access to care, and reduces the impact of churn

In implementing these innovations, Iowa anticipates advantages of the Marketplace Choice Plan around access, enrollee churn, and cost, will result in the long term cost-effectiveness of the Marketplace Choice Plan 1115 Demonstration.

Access

- Not only will Marketplace Choice Plan participants have greater access to health care providers than they would have in traditional fee-for-service Medicaid coverage due to increased reimbursement for providers but they

will not restrict the access to care of existing and future Medicaid recipients who must use Medicaid providers.

- Marketplace Choice Plan participants will have similar access to health care providers as others who are insured through the private market at fees that are generally higher than Medicaid fees. This will make the state more attractive for healthcare providers. An increased supply of healthcare providers has also been shown to improve access and health status.
- Due to their increased access, Marketplace Choice Plan participants will be able to more easily obtain preventive care services leading to better health status and lower long term health costs than otherwise.
- Marketplace Choice Plan participants with this increased access to providers will have decreased utilization of emergency department services as compared to Medicaid beneficiaries in traditional fee-for-service coverage.

Churn

- The use of the Marketplace for individuals who are at higher income percentages of MAGI will result in lower Medicaid administrative costs due to a reduction in the rate of churn, (beneficiaries moving from one program to another).
- Participants will experience fewer gaps in insurance coverage than traditional Medicaid beneficiaries since that they can remain in the same Marketplace health plan accessing the same providers even if their income increases and they are no longer eligible for the Marketplace Choice Plan.

Cost

- The use of the Marketplace Choice Plan for individuals who are at the higher qualifying 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 lives to the Marketplace resulting in increased competition in the private health insurance market leading to lower costs for all Iowans.
- The incentive program that reduces cost sharing in subsequent years will result in increased preventive care, other disease prevention, and health promotion activities, which will result in lower health costs and improved health status.
- The implementation of the Marketplace Choice Plan will lead to low uncompensated care costs for healthcare providers allowing them to lower their cost per service leading to lower overall cost per person.





Ms. Jennifer Vermeer
August 13, 2013

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Please do not hesitate to contact us if you have any questions regarding the enclosed information. You may contact me at (314) 231-3031.

Sincerely,

Timothy F. Harris, FSA, MAAA
Principal & Consulting Actuary

DRAFT

Milliman

Offices in Principal Cities Worldwide

Confidential Draft – For Discussion Purposes Only. This draft is intended for discussion purposes only. It should not be distributed to any third party, or published in whole or in part in any form, without prior written consent.