

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 & MEDICAID SERVICES**

**WAIVER LIST**

**NUMBER: 11-W-00289/5**

**TITLE: Iowa Wellness 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 Health and Wellness Plan section 1115 demonstration.

**1. Premiums**

**Section 1902(a)(14) and  
Section 1916**

To enable the state to charge premiums beyond applicable Medicaid limits to the Wellness demonstration populations above 50 percent of the federal poverty level, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income.

**2. 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 responsibility to assure transportation to and from providers for individuals in the new adult population who are not affected by the Marketplace Choice Plan demonstration. 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.

**3. 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 use of the emergency department. This copay will not apply to other Medicaid populations; copays applied to other Medicaid populations will not be

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

imposed on this population.

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

**NUMBER:** 11-W-00289/5

**TITLE:** Iowa Wellness Plan

**AWARDEE:** Iowa Department of Human Services

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for the Iowa Wellness Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of a requirement under section 1902(a) of the Social Security Act (the Act). 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. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Wellness 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. Benefits
- VI. Healthy Behaviors, Premiums, and Cost Sharing
- VII. Evaluation
- VIII. Monitoring

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

Under the approved Iowa Wellness Plan demonstration, for the new adult population that is eligible under the state plan group described in section 1902(a)(10)(A)(i)(VIII) and is not affected by the Marketplace Choice Plan demonstration, the state will be relieved of its responsibility to assure non-emergency transportation to and from providers for a one year period. Through this demonstration, the state will test and evaluate the effect of this change in state responsibilities on beneficiary access and utilization of services, and overall health status.

The Iowa Wellness Plan 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 between 50 percent and 100 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. At state option, nonpayment of these premiums can result in a collectible debt, but not loss of coverage for the enrollee. 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.

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

- Improving enrollee health and wellness through healthy behaviors and use of preventive services.
- Increasing enrollee engagement and accountability in their health care.

Iowa proposes to demonstrate whether monthly contributions and incentives for healthy behaviors improve enrollee health, and increase use of preventive services and healthy behaviors, without reducing access to care.

### 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 any population affected by the demonstration, 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 any necessary corresponding technical corrections 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 29; 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 associated with the quarter in which the forum was held. The State must also include the summary in its annual report.

**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 administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

#### **IV. POPULATIONS AFFECTED**

##### **17. Iowa Wellness Plan Population.**

The Iowa Wellness Plan is targeted for who are eligible in the new adult group under the State plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, who are not affected by the Marketplace Choice Plans demonstration, and who receive the ABP that is the Iowa Wellness plan.

#### **V. BENEFITS**

**18. Iowa Wellness Plan Benefits.** Individuals affected by this demonstration will receive benefits described in the Iowa Wellness Plan alternative benefit plan.

**19. 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.

#### **VI. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING**

##### **20. Premiums.**

- a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 24 and the state's ability to demonstrate statewide access under the standards set forth in STC 24(a)(ix).
- b. No premium will be charged for the first year of enrollment in the Iowa Wellness Plan.

- c. All premiums permitted by this paragraph are subject to the exemptions and waivers described in STC 21.
- d. Monthly premium amounts may not exceed \$5/month for nonexempt households from 50 up to 100 percent of the FPL and \$10/month for nonexempt households between 100-133 percent of the FPL.
- e. Enrollees will be allowed a 90 day premium grace period.
- f. The enrollee may not be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium.
- g. After 90 days, unpaid premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception:
  - i. If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

**21. Premium Exemptions.** Iowa Wellness Plan enrollees will be exempt from a monthly contribution obligation under the following conditions:

- a. For all individuals enrolled in the Iowa Wellness 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. Medically frail and members in the HIPP population are not subject to premiums.
- d. 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.

**22. 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.

**23. Iowa Wellness Plan Healthy Behaviors.** Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in STC 24 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 Wellness 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.

**24. 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.
- ix) Access data standards for which the state will supply baseline data establishing statewide access per STC 25 to allow for CMS approval of year 2 premium implementation:
  - (1) Statewide Access Standards. The state must achieve in any preceding year to the implementation of the premiums (and continue to maintain or improve), at a minimum, all of the following standards.

- (a) Statewide and/or regional access standards
- (b) Medicaid network slots to member ratio standards
- (c) Access to care standards including timeliness and actual primary care utilization in the enrolled population.
- (d) NCQA Element B standards
- (e) Data from monitoring of member hotline/complaint mechanism
- (f) Data from consumer surveys

### **Premiums**

- x) The process by which the state will identify individuals who are exempt from the premium requirements
  - xi) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
  - xii) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
  - xiii) 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 is 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 with overdue premiums including those with premiums past due less than and greater than 90 days.
  - v) Information about the state's collection activities.
  - vi) The number of individuals who have premiums that have become collectible debt.

- 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.

**25. Data Establishing Statewide Access.** The state will supply baseline data, in accordance with the protocol approved in STC 24(a)(ix), establishing statewide access by August 1, 2014, to allow for CMS approval of year 2 premium implementation

## **VII.EVALUATION**

**26. 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. CMS shall provide comment within 30 days of receipt from the state.

**27. 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.

**28. Evaluation Requirements.** The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate a final 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. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- e. The unique contributions and interactions of other initiatives; and
- f. 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.

**29. 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, 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 following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
  - ii. Health and Wellness enrollees will use preventative care services at a greater rate.
  - iii. Health and Wellness beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
  - iv. Additional types of payments above the regular fee-for-service payment for Primary Care Physicians (PCPs) incentive wellness activities in Health and Wellness enrollees will increase preventative services at a greater rate.
  - v. Premiums incentivize enrollees to complete healthy behaviors and do not pose an access to care barrier.
- 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 including consumer satisfaction and other indicators of consumer experience.
  - 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.

**30. Public Access.** The State shall post the final approved Evaluation Design on the State Medicaid website within 30 days of approval by CMS.

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

**32. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, 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.

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

**34. 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.

**35. Final Evaluation and Implementation.** The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

**36. Deferral for Failure to Provide Final Evaluation Reports on Time.** The State agrees that when Final 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.

## **VIII. MONITORING**

**37. 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, 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.

- 38. 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. 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.
- 39. Rapid Cycle Assessments.** The State shall specify for CMS approval a set of performance and outcome metrics, 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 the Health and Wellness Plan, and for monitoring and evaluation of the demonstration.

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

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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](mailto: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 12<sup>th</sup> Street  
Room 355  
Kansas City, MO 64106-2808  
Telephone: (816) 426-6417  
Email: [James.Scott1@cms.hhs.gov](mailto: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 & MEDICAID SERVICES**

**WAIVER LIST**

**December 30, 2013**

**NUMBER: 11-W-00289/5**

**TITLE: Iowa Wellness 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 Health and Wellness Plan section 1115 demonstration.

**1. Premiums**

**Section 1902(a)(14) and  
Section 1916**

To enable the state to charge premiums beyond applicable Medicaid limits to the Wellness demonstration populations above 50 percent of the federal poverty level, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income.

**2. 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 responsibility to assure transportation to and from providers for individuals in the new adult population who are not affected by the Marketplace Choice Plan demonstration. 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.

**3. 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.

Iowa Wellness Plan

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

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

**NUMBER:** 11-W-00289/5

**TITLE:** Iowa Wellness Plan

**AWARDEE:** Iowa Department of Human Services

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for the Iowa Wellness Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of a requirement under section 1902(a) of the Social Security Act (the Act). 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. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Wellness 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. Benefits
- VI. Healthy Behaviors, Premiums, and Cost Sharing
- VII. Evaluation
- VIII. Monitoring

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

Under the approved Iowa Wellness Plan demonstration, for the new adult population that is eligible under the state plan group described in section 1902(a)(10)(A)(i)(VIII) and is not affected by the Marketplace Choice Plan demonstration, the state will be relieved of its responsibility to assure non-emergency transportation to and from providers for a one year period. Through this demonstration, the state will test and evaluate the effect of this change in state responsibilities on beneficiary access and utilization of services, and overall health status.

The Iowa Wellness Plan 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 between 50 percent and 100 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. At state option, nonpayment of these premiums can result in a collectible debt, but not loss of coverage for the enrollee. 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.

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

- Improving enrollee health and wellness through healthy behaviors and use of preventive services.
- Increasing enrollee engagement and accountability in their health care.

Iowa proposes to demonstrate whether monthly contributions and incentives for healthy behaviors improve enrollee health, and increase use of preventive services and healthy behaviors, without reducing access to care.

### **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 any population affected by the demonstration, 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 any necessary corresponding technical corrections 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 29; 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 associated with the quarter in which the forum was held. The State must also include the summary in its annual report.

**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 administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

#### **IV. POPULATIONS AFFECTED**

##### **17. Iowa Wellness Plan Population.**

The Iowa Wellness Plan is targeted for who are eligible in the new adult group under the State plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, who are not affected by the Marketplace Choice Plans demonstration, and who receive the ABP that is the Iowa Wellness plan.

#### **V. BENEFITS**

**18. Iowa Wellness Plan Benefits.** Individuals affected by this demonstration will receive benefits described in the State's alternative benefit plan for the new adult group as set forth in the State ABP State plan.

**19. 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.

#### **VI. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING**

##### **20. Premiums.**

- a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 24 and the state's ability to demonstrate statewide access under the standards set forth in STC 24(a)(ix).
- b. No premium will be charged for the first year of enrollment in the Iowa Wellness Plan.

- c. All premiums permitted by this paragraph are subject to the exemptions and waivers described in STC 21.
- d. Monthly premium amounts may not exceed \$5/month for nonexempt households from 50 up to 100 percent of the FPL and \$10/month for nonexempt households between 100-133 percent of the FPL.
- e. Enrollees will be allowed a 90 day premium grace period.
- f. The enrollee may not be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium.
- g. After 90 days, unpaid premiums may be considered a collectible debt owed to the State of Iowa and, at state option, subject to collection by the state, with the following exception:
  - i. If, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment, unpaid premiums shall not be considered a collectible debt by the state.

**21. Premium Exemptions.** Iowa Wellness Plan enrollees will be exempt from a monthly contribution obligation under the following conditions:

- a. For all individuals enrolled in the Iowa Wellness 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. Medically frail and members in the HIPP population are not subject to premiums.
- d. 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.

**22. 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.

**23. Iowa Wellness Plan Healthy Behaviors.** Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in STC 24 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 Wellness 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.

**24. 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.
- ix) Access data standards for which the state will supply baseline data establishing statewide access per STC 25 to allow for CMS approval of year 2 premium implementation:
  - (1) Statewide Access Standards. The state must achieve in any preceding year to the implementation of the premiums (and continue to maintain or improve), at a minimum, all of the following standards.

- (a) Statewide and/or regional access standards
- (b) Medicaid network slots to member ratio standards
- (c) Access to care standards including timeliness and actual primary care utilization in the enrolled population.
- (d) NCQA Element B standards
- (e) Data from monitoring of member hotline/complaint mechanism
- (f) Data from consumer surveys

**Premiums**

- x) The process by which the state will identify individuals who are exempt from the premium requirements
  - xi) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
  - xii) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
  - xiii) 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 is 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 with overdue premiums including those with premiums past due less than and greater than 90 days.
  - v) Information about the state's collection activities.
  - vi) The number of individuals who have premiums that have become collectible debt.

- 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.

**25. Data Establishing Statewide Access.** The state will supply baseline data, in accordance with the protocol approved in STC 24(a)(ix), establishing statewide access by August 1, 2014, to allow for CMS approval of year 2 premium implementation

## **VII.EVALUATION**

**26. 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. CMS shall provide comment within 30 days of receipt from the state.

**27. 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.

**28. Evaluation Requirements.** The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate a final 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. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- e. The unique contributions and interactions of other initiatives; and
- f. 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.

**29. 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, 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 following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
  - ii. Health and Wellness enrollees will use preventative care services at a greater rate.
  - iii. Health and Wellness beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
  - iv. Additional types of payments above the regular fee-for-service payment for Primary Care Physicians (PCPs) incentive wellness activities in Health and Wellness enrollees will increase preventative services at a greater rate.
  - v. Premiums incentivize enrollees to complete healthy behaviors and do not pose an access to care barrier.
- 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 including consumer satisfaction and other indicators of consumer experience.
  - 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.

**30. Public Access.** The State shall post the final approved Evaluation Design on the State Medicaid website within 30 days of approval by CMS.

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

**32. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, 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.

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

**34. 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.

**35. Final Evaluation and Implementation.** The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

**36. Deferral for Failure to Provide Final Evaluation Reports on Time.** The State agrees that when Final 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.

## **VIII. MONITORING**

**37. 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, 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.

- 38. 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. 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.
- 39. Rapid Cycle Assessments.** The State shall specify for CMS approval a set of performance and outcome metrics, 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 the Health and Wellness Plan, and for monitoring and evaluation of the demonstration.



*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](mailto: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:

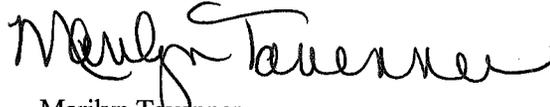
Centers for Medicare & Medicaid Services  
Richard Bolling Federal Building  
601 East 12<sup>th</sup> Street  
Room 355  
Kansas City, MO 64106-2808  
Telephone: (816) 426-6417  
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Page 3 – Ms. Jennifer Vermeer

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 & MEDICAID SERVICES**

**WAIVER LIST**

**December 10, 2013**

**NUMBER: 11-W-00289/5**

**TITLE: Iowa Health and Wellness 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 Health and Wellness Plan section 1115 demonstration.

**1. 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 responsibility to assure transportation to and from providers for individuals in the new adult population who are not affected by the Marketplace Choice Plan demonstration. 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.

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

**NUMBER:** 11-W-00289/5

**TITLE:** Iowa Health and Wellness Plan

**AWARDEE:** Iowa Department of Human Services

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for the Iowa Health and Wellness Plan section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of a requirement under section 1902(a) of the Social Security Act (the Act). 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. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Health and Wellness 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. Benefits
- VI. Evaluation
- VII. Monitoring

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

Under the approved Health and Wellness Plan demonstration, for the new adult population that is eligible under the state plan group described in section 1902(a)(10)(A)(i)(VIII) and is not affected by the Marketplace Choice Plan demonstration, the state will be relieved of its responsibility to assure non-emergency transportation to and from providers for a one year period. Through this demonstration, the state will test and evaluate the effect of this change in state responsibilities on beneficiary access and utilization of services, and overall health status.

**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 any population affected by the demonstration, 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 any necessary corresponding technical corrections 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 23; 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 associated with the quarter in which the forum was held. The State must also include the summary in its annual report.

- 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 administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

#### **IV. POPULATIONS AFFECTED**

**17. Iowa Wellness Plan Population.**

The Iowa Health and Wellness Plan is targeted for who are eligible in the new adult group under the State plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, who are not affected by the Marketplace Choice Plans demonstration, and who receive the ABP that is the Iowa Wellness plan.

**V. BENEFITS**

**18. Iowa Health and Wellness Plan Benefits.** Individuals affected by this demonstration will receive benefits described in the State’s alternative benefit plan for the new adult group as set forth in the State ABP State plan.

**19. Non-Emergency Medical Transportation (NEMT).** The Iowa Wellness Plan will 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 to allow for the state and CMS to consider the impact on access to care.

**20. Healthy Behaviors Incentives Standards.** 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. By March 31, 2014, the state shall submit for approval a protocol related to Healthy Behavior Incentives, including

- i) The purpose and objectives of the Healthy Behaviors Incentive program.
- ii) The methodology for obtaining, and criteria for, healthy behaviors to be met in order for incentives to be provided.
- iii) The process by which an enrollee is deemed to have met healthy behaviors.
- iv) The positive incentives that could be used for other health-related purposes, and the amount of positive incentives that can be earned on an annual basis.
- v) A list of stakeholders utilized in the development of the protocol.
- vi) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
- vii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.

**VI. EVALUATION**

**21. 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. CMS shall provide comment within 30 days of receipt from the state.

**22. 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.

**23. Evaluation Requirements.** The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate a final 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. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- e. The unique contributions and interactions of other initiatives; and
- f. 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.

**24. 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, 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 following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
- ii. Health and Wellness enrollees will use preventative care services at a greater rate.

- iii. Health and Wellness beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
  - iv. Additional types of payments above the regular fee-for-service payment for Primary Care Physicians (PCPs) incentive wellness activities in Health and Wellness enrollees will increase preventative services at a greater rate.
- 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 including consumer satisfaction and other indicators of consumer experience.
- 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.

**25. Public Access.** The State shall post the final approved Evaluation Design on the State Medicaid website within 30 days of approval by CMS.

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

**27. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, 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.

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

**29. 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.

**30. Final Evaluation and Implementation.** The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft

evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

**31. Deferral for Failure to Provide Final Evaluation Reports on Time.** The State agrees that when Final 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**

**32. 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, 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.

**33. 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. 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.

**34. Rapid Cycle Assessments.** The State shall specify for CMS approval a set of performance and outcome metrics, 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 the Health and Wellness Plan, and for monitoring and evaluation of the demonstration.

# Iowa Department of Human Services



*Iowa Wellness Plan  
1115 Waiver Application*

August 2013

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## Introduction

Iowa has a history of health care innovation and commitment to the working poor population. From the IowaCare 1115 demonstration waiver that served over 172,000 Iowans with income up to and including 200 percent of the federal poverty level (FPL) to the State Innovation Models grant to implement state-wide multi-payor Accountable Care Organizations (ACOs), Iowa has demonstrated dedication to innovative health options for low-income populations.

Continuing with this history of health care innovation, in May of 2013 the Iowa Legislature passed the Iowa Health and Wellness Plan. Working in tandem with the advance premium tax credits that will be available in 2014, this plan 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 and will implement three options that offer coverage to adults ages 19 through 64 with income not exceeding 133 percent of the FPL.<sup>1</sup> Current members on IowaCare who are above 133 percent of the FPL will be eligible to receive advance premium tax credits through the Iowa Marketplace. The three components of the Iowa Health and Wellness Plan are: (1) the Iowa Wellness Plan serving eligible individuals with income up to and including 100 percent of the FPL and medically frail eligible individuals with income up to and including 133 percent of the FPL through a 1115 demonstration that promotes coordinated care, managed care, and the development of ACOs; (2) the Marketplace Choice Plan serving non-medically frail individuals with income 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 health insurance marketplace (Marketplace); and (3) providing premium assistance for individuals with income up to and including 133 percent of the FPL who have access to cost-effective employer sponsored insurance (ESI) coverage under Iowa's Health Insurance Premium Payment (HIPP) Program. By implementing two separate 1115 demonstrations and expanding the HIPP Program for 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. With implementation of these two demonstrations and the utilization of the HIPP Program, by 2016 Iowa expects to provide coverage to approximately 190,000 adults ages 19 through 64 with income not exceeding 133 percent of the FPL.

This 1115 waiver request seeks to implement the Iowa Wellness Plan and coverage options for eligible individuals, who do not have access to a cost-effective ESI health plan, with income up to and including 100 percent of the FPL and for eligible medically frail individuals with income up to and including 133 percent of the FPL. A separate 1115 waiver request to implement the Marketplace Choice Plan will be submitted to the Centers of Medicare and Medicaid Services (CMS) concurrently with this request that will cover the eligible non-medically frail population with income from 101 percent of the FPL up to and including 133 percent of the FPL that is

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<sup>1</sup> With the 5 percent of FPL disregard, 133 percent of the FPL will include individuals with income up to and including 138 percent of the FPL. All notations of 133 percent of the FPL in this document are inclusive of the percent disregard to 138 percent of the FPL unless otherwise stated.

more likely to transition to Iowa Marketplace coverage. This Iowa Wellness Plan demonstration simultaneously promotes delivery system innovation, care management, care coordination and quality for eligible individuals with income up to and including 100 percent of the FPL and for medically frail individuals with income up to and including 133 percent of the FPL. 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.

With the Iowa Wellness Plan, Iowa ensures coverage options for Iowans ages 19 through 64, with income up to and including 100 percent of the FPL and for medically frail Iowans with income up to and including 133 percent of the FPL who do not have access to cost-effective ESI coverage. The Iowa Wellness Plan's approaches to coverage are designed to realign the delivery system to focus on value, quality, and coordination of care. Through a phased implementation, the Iowa Wellness Plan promotes coordinated care through primary care coordination, managed care, and the State Innovation Model ACOs. This 1115 waiver request seeks to not only provide coverage to low income Iowans but to create a framework that supports innovations and results in higher quality and lower premium costs for all Iowans by investing in new delivery system models.

The Iowa Wellness Plan targets individuals ages 19 through 64, who are not eligible for other categories of Medicaid or Medicare or who do not have access to cost-effective ESI coverage, and who have income not exceeding 100 percent of the FPL or are medically frail and have income not exceeding 133 percent of the FPL. Those with cost-effective ESI coverage will be provided with premium support to access their employer's health plan through Iowa's existing HIPP Program. Those found eligible for the Iowa Wellness 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. Individuals who qualify as medically frail will be defaulted to enrollment in the Medicaid State Plan where benefits are more appropriate to their needs; however, these individuals will have the opportunity to opt-out of Medicaid State Plan coverage and receive coverage on the Iowa Wellness Plan. Eligibility for individuals determined to be medically frail extends to 133 percent of the FPL to assure that these individuals with more comprehensive health care needs can benefit from the delivery system innovations of the Iowa Wellness Plan if they opt-out of the Medicaid State Plan coverage. In addition, Iowa will screen all eligible individuals for access to a cost-effective ESI health plan. If an individual has access to a cost-effective ESI health plan, he or she will not be enrolled in the Iowa Wellness Plan but will receive premium assistance for the cost-effective ESI health plan through the existing HIPP Program.

The Iowa Wellness Plan will provide a comprehensive commercial-like benefit plan that ensures provision of the Essential Health Benefits (EHB) and is indexed to the State Employee Plan benefits with supplemental dental benefits, similar to those provided on the Medicaid State Plan. Mental health and substance use disorder and dental benefits will be provided as carved out benefits on a contracted basis. Enrollment projections indicate that by 2016, 115,896 individuals will be covered through the Iowa Wellness Plan and an additional 19,032 individuals with

income under 100 percent of the FPL will be covered through premium assistance for cost-effective ESI coverage through the HIPP Program. Detailed enrollment projections are discussed in Section 6.2.

The Iowa Wellness Plan creates an innovative approach to providing health care services to Iowa's low-income, adult population and assures coverage options for all Iowans. This waiver request promotes care management, coordination, and quality and seeks to support the development of ACOs across the State in concert with the State Innovation Model goals. However, recognizing that ACO and managed care penetration vary across Iowa, this request allows for different delivery and payment models. Starting in January 2014, the Iowa Wellness Plan will provide health care coverage by promoting coordinated care through a variety of mechanisms including primary care physician coordination, ACOs, as well as managed care models. The model will vary by geographic region and will depend on the delivery system readiness for ACOs and/or managed care. However, at a minimum, all members will have access to primary care that provides referrals and care coordination and focuses on quality outcomes. Over the course of the demonstration, and as ACO development increases across Iowa, more Iowa Wellness Plan members will be covered by primary care physicians who are associated with ACOs.

The Iowa Wellness 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 who complete preventive health service requirements. Members with income exceeding 50 percent of the FPL will be required to contribute financially toward their health care costs through monthly contributions. Since required monthly financial contributions could be challenging for the lowest income individuals, those with income below 50 percent of the FPL will not be subject to the required 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 year of enrollment in the Iowa Wellness 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, and such targeted behaviors will be defined by Iowa 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. In addition, members subject to the required financial contribution will have the opportunity to request a hardship waiver if they cannot afford to make their monthly payment. The required financial contributions are the only cost sharing required of Iowa Wellness Plan members other than copayments for non-emergency use of the emergency department, which apply to all members regardless of income level but are also waived in the initial demonstration year.

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

## **Section 1: Program Description**

The Iowa Wellness Plan is designed to cover individuals ages 19 through 64 with income not exceeding 100 percent of the FPL through a State operated program that provides an incentive program to improve the use of preventive care services, promotes other positive health behaviors, and leverages care coordination through the use of gate keeper primary care physicians (PCP), managed care, and ACOs.

Eligible individuals, who do not have access to cost-effective ESI coverage, with income up to and including 100 percent of the FPL will receive benefits that are consistent with commercial market EHBs and are indexed to the State Employee Plan benefits. Eligible individuals who are medically frail with incomes up to 133 percent of the FPL will be enrolled in Medicaid State Plan benefit coverage, but will be able to opt-out of the Medicaid State Plan Coverage and receive the Iowa Wellness Plan coverage offered to non-medically frail individuals. Iowa Wellness Plan benefits will be delivered through a coordinated primary care system that will leverage both managed care and ACOs. Medically frail individuals who do not opt-out of Medicaid State Plan coverage will have access to services including 1915(i) habilitation services and integrated health and/or medical homes that may be more appropriate for their health care needs. Individuals will be screened for access to cost-effective ESI prior to enrollment in the Iowa Wellness Plan. Those individuals with access to a cost-effective ESI health plan will not be enrolled in the Iowa Wellness Plan but will be provided with premium support to access their employer's health plan through Iowa's existing HIPPP Program.

The Iowa Wellness Plan promotes responsible health care decisions by coupling a monthly-required financial contribution with an incentive plan for members to actively seek preventive health services and earn an exemption from the monthly contribution requirement. During their first 12 months of enrollment, members will not be required to make financial contributions toward their care. After their first 12 months of enrollment, members with income exceeding 50 percent of the FPL will be required to pay a required monthly contribution. However, the required contribution will be waived if the participant completed all Iowa Wellness Plan targeted preventive health behaviors or other services, such as a health risk assessment or an annual physical in the preceding 12-month enrollment period. Iowa may develop other criteria related to health promotion and preventive services over time. For example, Iowa may consider adherence and completion of a disease management program as criteria for certain high-risk members. If members do not complete the health improvement behaviors, they will have the opportunity to request a hardship waiver if they cannot afford to pay their monthly contribution. Members with income up to and including 50 percent of the FPL are not required to pay a monthly financial contribution. Details regarding the monthly financial contribution requirements are outlined in Section 4.

The Iowa Wellness Plan will not require any copayments for services, with the exception of copayments for non-emergency use of the emergency department - a policy which is also waived in year one. 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 Iowa Wellness Plan. This level of contribution ensures that members can make their monthly

contribution amounts without reaching the federal 5 percent out-of-pocket maximum limit, even if they make copayments for emergency department use.

In addition to a unique health incentive program, the Iowa Wellness Plan will debut an innovative delivery system and payment methodology. While ACOs are in the process of being developed statewide, there is not currently statewide coverage by ACO entities. Additionally, Iowa has managed care plans available in certain locations, but these organizations are also not necessarily statewide. In this demonstration request, Iowa works to leverage all available delivery system models and providers that coordinate care for members. All Iowa Wellness Plan members will have choices related to the provision of care. At minimum, Iowa Wellness Plan members will have a choice of a PCP and, if available in their geographic location, they may have the choice of a managed care plan(s). Some of the PCPs available to Iowa Wellness Plan members may be associated with ACOs if there is an ACO developed in the region. The PCPs, managed care plans, and ACOs will all be leveraged to assure care management, coordination of care, and a focus on improving health outcomes. Members who select a PCP will have access to the full Medicaid provider network and those enrolled in the managed care plan will access the plan's network, which will be subject to network adequacy and access standards. With state approval, for members associated with an ACO, the ACO may limit network choice for the purposes of providing more integrated, coordinated care and/or higher quality care.

PCPs, whether associated with an ACO or not, will coordinate member care by conducting referrals, managing and monitoring member health, and assisting with management of complex and chronic conditions. PCPs who are not associated with an ACO will be paid on a fee-for-service basis and provided a per member per month (PMPM) payment to coordinate member care and provide referrals. PCPs will also be eligible for bonus payments based on quality and process improvements. Managed care plans will be compensated through capitation and will also be held to quality standards. PCPs that are associated with ACOs will be paid on a fee-for-service basis and quality incentives will be aggregated to the ACO. In subsequent demonstration years, ACOs will be subject to a risk adjusted global budget and may qualify for shared savings based on quality outcomes. Consistent with the State Innovations Models Grant, two-sided risk will be eventually implemented for ACOs over the course of the demonstration.

### 1.1 Demonstration Purpose

Three objectives have driven the development of the Iowa Wellness Plan.

- 1) The Iowa Wellness Plan is designed to offer coverage options for individuals who do not have access to cost-effective ESI coverage with income not exceeding 100 percent of the FPL and for medically frail Iowans with income not exceeding 133 percent of the FPL, who are ages 19 through 64, and are not otherwise eligible for Medicaid, Medicare, or subsidized Iowa Marketplace coverage. Combined with current Medicaid and Medicare coverage options, the Marketplace Choice Plan waiver submitted to CMS simultaneously with this request, and subsidized coverage through the Marketplace, 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 care coordination.

- 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.

### 1.2 Demonstration Hypotheses

The innovations in the Iowa Wellness Plan include participant incentives, development of ACOs, a delivery system model that incorporates PCPs, managed care plans, and ACOs, and a payment model for ACOs based on global budget amounts. In implementing these innovations, the Iowa Wellness Plan will investigate the following three research areas.

- 1) Through implementation of the Iowa Wellness Plan, Iowa seeks to understand if the incentive program that eliminates required contributions in subsequent years results in increased preventive care and other disease prevention and health promotion activities in the current year.
- 2) The Iowa Wellness Plan will allow Iowa to investigate if the development of ACOs improves quality and value for members, as compared to the traditional primary care coordination model or managed care. Iowa seeks to understand if ACOs can coordinate care for members to increase positive health outcomes compared to individuals served by only PCPs or covered by managed care plans, and if the ACO quality goals translate to improved value and health status for members.
- 3) The Iowa Wellness Plan includes a unique payment methodology for ACOs based on a combination of fee-for-service payments, global budgets, and shared savings based on achievement of quality metrics. By implementing the Iowa Wellness Plan, Iowa seeks to understand if the payment model is effective in promoting increased quality and controlling costs in comparison to the fee-for-service and care coordination payment model for PCPs and the capitation payment model for managed care plans.

The following table displays individual hypotheses and evaluation parameters targeted to these research areas.

**Table 1: Iowa Wellness Plan Initial Hypotheses and Evaluation Parameters**

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
<b>Access</b>						
1	To test that PCP coordination and ACO development promote appropriate provider access.	Iowa Wellness Plan members will have comparable access to health care providers as they would have had in traditional fee-for-service Medicaid coverage.	<p>Compare service utilization between Iowa Wellness Plan members and traditional Medicaid members</p> <p>Compare quality and outcome metrics</p>	Traditional Medicaid members	<p>Percent of members who report having a primary care physician</p> <p>Percent 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 member satisfaction data</p>
2	To test the impact of the waiver for the provision of non-emergency transportation services on the Iowa Wellness Plan population.	The waiver of non-emergency transportation services does not pose a barrier to access of care for Iowa Wellness Plan members.	<p>Review members' ability to access care in comparison with traditional Medicaid members.</p> <p>Compare members' use of emergency transportation, adherence to appointments, preventive care visits, and adherence to appropriate care regimens to traditional Medicaid</p>	Traditional Medicaid population	Access to care metrics including use of emergency transportation, adherence to appointments, number of preventive care visits, and adherence to	Claims data

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			members.		appropriate care regimens.	
3	To test the impact on access to care of mandatory enrollment for individuals with cost-effective ESI.	Individuals with cost-effective ESI who are mandatorily enrolled in that coverage have comparable access to care as individuals enrolled in the Iowa Wellness Plan.	Conduct a survey of Iowa Wellness Plan members and those enrolled in cost-effective ESI.	Iowa Wellness Plan members	Percent of members who report having a primary care physician  Percent of members who report they get care quickly when needed	Wellness Plan Survey
4	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 Iowa Wellness Plan members.	Conduct a survey of EPSDT eligible Wellness 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. Vision and hearing aid services will be the main eliminated benefits.	Traditional Medicaid population	Percent of qualifying members (ages 19 & 20) that report unmet need or inability to pay for vision or hearing services.	Wellness Plan Survey
<b>Cost Sharing</b>						

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
5	To test the impact of the income indexed 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 financial contribution requirement does not pose an access to care barrier for Iowa Wellness Plan members.	<p>Compare the experience of members who are subject to the monthly payment to the experience of members who complete preventive services in the prior year and are not subject to this payment.</p> <ul style="list-style-type: none"> <li>Survey members who are subject to the required financial contribution to determine if the amount of financial contribution is reasonable for members.</li> </ul> <p>Analyze experience of members who do not pay within the 60-day grace period and are disenrolled.</p> <ul style="list-style-type: none"> <li>What percent of these members reenroll?</li> <li>Survey disenrolled members to determine reason for disenrollment.</li> </ul> <p>Analyze the percent of members that are subject to the financial contribution in year 2 who receive preventive services in that year.</p> <ul style="list-style-type: none"> <li>Survey members to determine if being subject to required contribution impacted their decision making around seeking preventive care</li> </ul>	<p>Iowa Wellness Plan members not subject to \$20 payment</p> <p>Iowa Wellness Plan Members not disenrolled</p> <p>Iowa Wellness Plan members who request a hardship exemption.</p> <p>Traditional Medicaid</p>	<p>Member knowledge of the program</p> <p>Member report on if the financial contribution is 'too low, just right, too high'</p> <p>Member 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>Wellness Plan Member Survey</p> <p>Enrollment data</p>

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			<p>Analysis of the members who are subject to the contribution but request a hardship waivers.</p> <ul style="list-style-type: none"> <li>• What are the distinguishing characteristics of members who do or do not request hardship waivers?</li> <li>• Are members aware of the hardship waivers?</li> <li>• How many members request hardship waivers?</li> </ul> <p>Examine access and quality of care for members subject to and not subject to required contributions</p>			
6	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 Iowa Wellness Plan 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 amounts for non-emergency use of the emergency department in Iowa and other States.</p>	<p>Traditional Medicaid</p> <p>Other States' Medicaid populations</p>	<p>Member response- if copayment impacted decision making on emergency department use</p> <p>Member response- if copayment was 'too low, just right, too high'</p>	<p>Wellness Plan Member Survey</p> <p>Hospital emergency department use data</p>
<b>Utilization</b>						
7	To test if the financial contribution that is implemented in year 2 if members do not	Iowa Wellness Plan members will use preventive care services at a greater rate compared to the traditional	Compare the percent of Iowa Wellness Plan members with a preventive care visit in the last year to the traditional Medicaid	Traditional Medicaid population	Rate of preventive care utilization	CDC- Behavioral Risk Factor Surveillance System

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
	receive services in year 1 is effective at encouraging member use of preventive care.	Medicaid members and will have a comparable or greater rate or preventive service utilization as commercial market members and Marketplace Choice Plan members.	population, Medicaid expansion populations in non-premium assistance states, and the commercial market.	Commercial Market population  Marketplace Choice Plan members  Medicaid expansion populations in other states		Claims Data  <i>Potential: Other State Expansion Data on Preventive Care Utilization</i>
8	To test if the cost sharing policy related to non-emergency use of the emergency department is effective at reducing non-emergency department visits.	Iowa Wellness 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 Marketplace Choice Plan and commercial populations.	Compare the percent of persons with hospital emergency department as usual source of care to traditional Medicaid.  Compare non-emergent use of the emergency department in the Iowa Wellness Plan to that of traditional Medicaid.	Traditional Medicaid  Marketplace Choice Plan  Commercial Market populations	Percent of Iowa Wellness Plan members that report the emergency department as usual source of care  PMPM non-emergent emergency department visits	Claims Data  CAHPS  NCQA HEDIS  MEPS
<b>Quality</b>						
9	To test if the Iowa Wellness Plan results in increased quality for members.	The Iowa Wellness Plan and its emphasis on care coordination will result in increased quality of care and better outcomes for members as compared to traditional	Compare Iowa Wellness Plan quality and outcome metrics with traditional Medicaid.	Traditional Medicaid	SIM Quality Metrics to include:  Attributed member experience	Quality metric data reported from QHPs  CAHPS  NCQA HEDIS

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
		Medicaid.			Primary and secondary prevention  Tertiary prevention  Population health status  Continuity of care  Chronic and follow-up care  Outcome metrics: including: asthma hospital readmissions, diabetes related amputation, provision of appropriate care regimens, etc.	QHP Member Satisfaction Survey
10	To examine the impact of the promotion of care coordination in the Iowa Wellness Plan.	Care coordination will be superior in the Iowa Wellness Plan to traditional Medicaid.	Utilize AHRQ Care Coordination measures and tools to examine care coordination in the Iowa Wellness Plan  Conduct member and provider surveys to understand the impact of care coordination  Compare quality and outcome	Traditional Medicaid	AHRQ Care Coordination Measure	Claims data  Provider & Member Survey  National Data Sets

#	Purpose	Hypothesis	Methodology	Comparison Groups	Potential Metrics	Potential Data Sources
			metrics in the Iowa Wellness Plan with traditional Medicaid			

### 1.3 Demonstration Area

The Iowa Wellness Plan will be offered across the entire state; however the options offered to members in different areas of the state will vary based on the availability of managed care plans, PCPs, and ACOs.

### 1.4 Demonstration Timeframe

Implementation of the Iowa Wellness Plan will initiate upon program approval, with the goal of full program implementation and initiation of coverage by January 1, 2014. Approval for the initial demonstration is requested for the maximum allowable period of five years for a full demonstration timeframe of 2014 through 2018.

### 1.5 Demonstration Impact to Medicaid and CHIP

Iowa intends to utilize the modified adjusted gross income (MAGI) methodology for income eligibility to align the Iowa Wellness Plan eligibility with Medicaid, CHIP, and the Marketplace. As an overall strategy to streamline the Medicaid program and reduce duplicate coverage options available in 2014, Iowa intends to discontinue the fully state funded coverage of the “dependents” under the State supplementary group, Dependent Persons. The “dependents” currently enrolled in this coverage option will be transitioned to coverage provided through the Iowa Wellness Plan, the Marketplace Choice Plan, or the Iowa Marketplace.

## Section 2: Demonstration Eligibility

The Iowa Wellness Plan is targeted for individuals who are ages 19 through 64 who do not have access to Medicare or other comprehensive Medicaid coverage, and who are not eligible for cost-effective ESI coverage. Individuals, who do not have access to cost-effective ESI coverage, with income up to and including 100 percent of the FPL based on MAGI methodology, are considered eligible, and individuals with income up to 133 percent of the FPL who are medically frail will be considered eligible.

### 2.1 Eligibility Groups

The Iowa Wellness Plan is targeted specifically at a subset of the ACA new adult group. Those who have income up to and including 100 percent of the FPL based on MAGI methodology and those who are medically frail with incomes up to and including 133 percent of the FPL based on MAGI methodology are eligible for the Iowa Wellness Plan provided they do not have access to cost-effective ESI coverage. Individuals eligible for cost-effective ESI coverage will be enrolled in that coverage through the HIPP Program on the Medicaid State Plan and will be provided with appropriate HIPP Program wrap services.

**Table 2: Eligibility**

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
<b>The Adult Group – Non-medically Frail</b>	1902(a)(10)(A)(i)(VIII)	0 – 100 percent of FPL
<b>The Adult Group – Medically Frail</b>	1902(a)(10)(A)(i)(VIII) 42 CFR §440.315(f)	0 – 133 percent of FPL

Individuals applying for the Iowa Wellness Plan will be screened prior to enrollment to determine if they qualify as medically frail. Those individuals who meet the medically frail qualification will be defaulted to enrollment in Medicaid State Plan coverage. However, these individuals may opt-out to coverage under the Iowa Wellness Plan. More detail on the medically frail screening process is available in Section 3.5.

## 2.2 Eligibility Standards and Methods

Eligibility for the Iowa Wellness Plan will be determined on MAGI based calculations. Individuals ages 19 through 64, are eligible for Medicaid in other comprehensive coverage categories, are eligible for Medicare, have income in excess of 100 percent of the FPL based on MAGI for the non-medically frail, have income in excess of 133 percent for the medically frail, or have access to cost-effective ESI coverage are not eligible for the Iowa Wellness Plan demonstration.

Individuals who have access to cost-effective ESI coverage will receive premium assistance administered through Iowa's HIPP Program. Non-medically frail individuals with income 101 percent of the FPL up to and including 133 percent of the FPL will receive coverage through the Marketplace Choice Plan 1115 waiver demonstration, submitted to CMS in concert with this request.

Prior to enrollment, a process will be implemented to determine if the individual is medically frail. Those considered medically frail will be defaulted to enrollment in Medicaid State Plan coverage and, as required by federal legislation, will not be mandatorily enrolled into an Alternative Benefit Plan. The medically frail will have the opportunity to opt-out of the Medicaid State Plan coverage into the coverage provided to non-medically frail individuals on the Iowa Wellness Plan. Medically frail individuals who opt-out of the Medicaid State Plan coverage will not be provided with wrap services for more comprehensive benefits offered on the Medicaid State Plan. In order to receive services, including 1915(i) habilitation services, medically frail individuals are required to remain enrolled in Medicaid State Plan coverage. More information on the medically frail enrollment process can be found in Section 3.5.

Individuals enrolled in the Iowa Wellness Plan who become eligible for another Medicaid eligibility category per a redetermination will be transferred to that category, as appropriate.

## 2.3 Projected Eligibility and Enrollment

By 2016, an estimated 116,000 Iowans are projected to be enrolled through the Iowa Wellness Plan either as medically frail and covered through the Medicaid State Plan, with the opportunity to opt-out to the Iowa Wellness Plan, or as non-medically frail and covered through the Iowa Wellness Plan.

Expected year-by-year enrollment for the full demonstration period of five years is detailed below in Table 3. Though they will not be enrolled on the Iowa Wellness Plan, this table also provides estimates for the individuals with income under 100 percent of the FPL who have access to a cost-effective ESI health plan and become eligible for the HIPP Program due to the Iowa Health and Wellness Plan legislation.

**Table 3: Projected Iowa Wellness Plan and HIPP Enrollment**

	2014	2015	2016	2017	2018
<b>Wellness Plan Population (ACO) FPL ≤100 percent</b>	79,076	97,003	98,458	99,935	101,434
<b>Medically Frail Population (Default Medicaid State Plan) FPL ≤133 percent</b>	14,892	17,153	17,411	17,673	17,938
<b>Total</b>	<b>93,968</b>	<b>114,156</b>	<b>115,869</b>	<b>117,608</b>	<b>119,372</b>
<b>HIPP Enrollment (Cost-effective ESI) FPL ≤100 percent</b>	<b>12,316</b>	<b>18,751</b>	<b>19,032</b>	<b>19,317</b>	<b>19,607</b>

It is estimated that all of the individuals with income up to and including 100 percent of the FPL currently enrolled in the IowaCare 1115 demonstration will enroll in the Iowa Wellness Plan; and their take up rate will be 100 percent as of 2014. Additionally, it is estimated that medically frail individuals enrolled in the IowaCare 1115 demonstration up to 133 percent of the FPL will have a 100 percent take up rate and will enroll in the Iowa Wellness Plan and be defaulted to Medicaid State Plan Coverage. IowaCare 1115 demonstration members will be invited to apply for the Iowa Wellness Plan and outreach will be conducted to explain the new program components. As shown in Table 3, enrollment of the eligible population who are not currently enrolled in the IowaCare 1115 demonstration and who do not have access to cost-effective ESI coverage is expected to increase over two years with 60 percent of the potential members enrolling in the first year and 30 percent enrolling in the second year. It is estimated that 10 percent of those potentially eligible for the Iowa Wellness Plan will choose other medical assistance options. For years 2016 through 2018, enrollment is projected to increase at a natural growth rate of 1.5 percent annually.

#### 2.4 Eligibility for Long Term Services and Supports

The Iowa Wellness Plan will not cover long term services and supports (LTSS). Individuals who need LTSS, including 1915(i) habilitation services, will be considered medically frail and will be defaulted to coverage through the Medicaid State Plan. Medically frail individuals may opt-out of the Medicaid State Plan into the Iowa Wellness Plan but will not receive LTSS services as a wrap-around if they do so. More information on how the Iowa Wellness Plan will screen for and

assure default coverage through the Medicaid State Plan for the medically frail can be found in Section 3.5.

### 2.5 Changes to Eligibility Procedures

The Iowa Wellness Plan does not seek any waivers for eligibility procedures. Iowa will use the MAGI methodology to assess eligibility for the Iowa Wellness Plan.

### 2.6 2014 Eligibility

The Iowa Wellness Plan will initiate January 1, 2014, in concert with the ACA new adult group based on MAGI eligibility standards.

## Section 3: Benefits

The Iowa Wellness Plan members will receive a comprehensive, commercial-like benefit package based on the State Employee Plan benefits, which will ensure coverage for all of the EHBs as required by the ACA. Iowa will supplement the State Employee Plan services with supplemental dental benefits, similar to those provided in the Medicaid State Plan. Mental health and substance use disorder and dental benefits will be provided on as carved out benefits on a contracted basis. The benefits listed in Table 4 are consistent with the State Employee Plan unless otherwise noted.

### 3.1 Benefit Chart

**Table 4: Benefit Package**

Eligibility Group	Benefit Package
<p><b>The Adult Group</b></p> <ul style="list-style-type: none"> <li>• <b>Non-medically frail 0-100 percent of the FPL</b></li> <li>• <b>Medically frail 0-133 percent of the FPL<sup>2</sup></b></li> </ul>	<p>Secretary Approved Coverage to include dental services. Benefits based on State Employee Plan.</p>

### 3.2 Social Security Act Section 1937 Alternative Benefit Plans

The Iowa Wellness Plan will utilize the Secretary Approved Alternative Benefit Plan (ABP) coverage option under Section 1937 of the Social Security Act to provide benefits for eligible individuals. The Secretary Approved ABP option will be indexed to State Employee Plan benefits as directed by the enabling legislation. The ABP will provide supplemental dental services similar to the Medicaid State Plan. Mental health and substance use disorder and dental benefits will be provided as a carved out benefits on a contracted basis. As required by 42 CFR §440.315(f), members identified as medically frail will not be mandatorily enrolled in the ABP coverage. Instead, those designated as medically frail will be defaulted to coverage through the Medicaid State Plan where they can access services not provided by the ABP, including 1915(i) habilitation services. Medically frail individuals will have the opportunity to opt out of Medicaid State Plan coverage and receive ABP coverage under the Iowa Wellness Plan.

<sup>2</sup> Medically frail individuals will be defaulted into State Plan coverage; however, they will be able to opt-out of the State Plan and receive coverage through the Iowa Wellness Plan ABP.

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.

### 3.3 Covered Benefits

Benefits under the Iowa Wellness Plan are indexed to the benefits offered through the State Employee Plan. Waiver of the requirements to offer non-emergency transportation services and Early Periodic Screening, Diagnoses, and Testing (EPSDT) services to individuals ages of 19 and 20 are being requested to standardize the benefit package for members on the Iowa Wellness Plan, the Marketplace Choice Plan, and individuals receiving subsidized coverage through the Iowa Marketplace. All medical benefits will be provided through the current Iowa Medicaid contracted provider network. Supplemental dental benefits are offered to the Iowa Wellness Plan members, the medically frail population with coverage under either the Medicaid State Plan or the Iowa Wellness Plan, and those individuals with cost-effective ESI coverage that do not have access to dental services. Dental benefits will be similar to the Medicaid State Plan dental benefits. Mental health and substance use disorder and dental benefits will be provided as carved out benefits on a contracted basis.

**Table 5: Covered Benefits Chart**

Benefit	Description of Amount, Duration and Scope	Reference
EHB Category: Ambulatory Patient Services		
Primary Care Physician Services <sup>3</sup>	Covered Service. Provided through participant's primary care provider (PCP).	1905(a)(5)
Specialty Physician Visits	Covered Service. Provided by referral of member's PCP.	1905(a)(5)
Home Health Services	Covered service as recommended by PCP or referred specialist.	1905(a)(7)
Chiropractic Care	Covered service.	1905(a)(6)
Outpatient Surgery	Covered service as recommended by PCP or referred specialist.	1905(a)(2)
Second Surgical Opinion	Covered service as recommended by PCP or referred specialist.	1905(a)(2)
Allergy Testing	Covered service as recommended by PCP or referred specialist.	1905(a)(13)
Chemotherapy	Covered service as recommended by PCP or referred specialist.	
IV Infusion Services	Covered service as recommended by PCP or referred specialist.	
Radiation Therapy	Covered service as recommended by PCP or referred specialist.	
Dialysis	Covered service as recommended by PCP or referred specialist.	

<sup>3</sup> Includes advanced practice registered nurse practitioners (APRNs).

Benefit	Description of Amount, Duration and Scope	Reference
Dental Services	Covered service. Benefits similar to the Medicaid State Plan benefit. Dental services are carved out benefit and provided on a contractual basis.	2105(c)(5)
<b>EHB Category: Emergency Services</b>		
Emergency Room Services	Covered service. Non-emergency visits to the emergency department subject to \$10 copayment after initial demonstration year.	1905(a)(29)
Emergency Transportation-Ambulance and Air Ambulance	Covered service.	
Urgent Care/Emergency Clinics (non-hospital)	Covered service.	
<b>EHB Category: Hospitalization</b>		
General Inpatient Hospital Care	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Inpatient Physician Services	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Inpatient Surgical Services	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Non-Cosmetic Reconstructive Surgery	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Transplants	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Congenital Abnormalities Correction	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Anesthesia	Covered service as recommended by PCP or referred specialist.	1905(a)(1)
Hospice Care	Covered service as recommended by PCP or referred specialist.	1905(a)(18)
Hospice Respite	Covered as recommended by PCP or referred specialist. 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 service as recommended by PCP or referred specialist, limited to 120 days annually.	1905(a)(4)
<b>EHB Category: Mental Health and Substance Abuse</b>		
Mental/Behavioral Health Inpatient Treatment	Covered service. Mental health is a carved out benefit provided on a contracted basis through the Iowa Plan. Those with disabling mental disorders will be considered medically frail and enrolled in the Medicaid State Plan.	1905(a)(1)

Benefit	Description of Amount, Duration and Scope	Reference
Mental/Behavioral Health Outpatient Treatment	Covered service. Mental health is a carved out benefit provided on a contracted basis through the Iowa Plan. Those with disabling mental disorders will be considered medically frail and enrolled in the Medicaid State Plan.	1905(a)(2)
Substance Abuse Inpatient Treatment	Covered service. Substance Abuse treatment is a carved out benefit provided on a contracted basis through the Iowa Plan. Those with disabling substance abuse disorders will be considered medically frail and enrolled in the Medicaid State Plan.	1905(a)(1)
Substance Abuse Outpatient Treatment	Covered service. Substance Abuse treatment is a carved out benefit provided on a contracted basis through the Iowa Plan. Members with disabling substance abuse disorders will be considered medically frail and enrolled in the Medicaid State Plan.	1905(a)(2)
<b>EHB Category: Prescription Drugs</b>		
Prescription Drugs	Covered service as recommended by PCP or referred specialist.	1905(a)(12)
<b>EHB Category: Rehabilitative and Habilitative Services and Devices</b>		
Physical Therapy, Occupational Therapy, Speech Therapy	Covered service as recommended by PCP or referred specialist. Limited to a combined 60 visits annually.	1905(a)(11), 1905(a)(13)
Durable Medical Equipment	Covered service as recommended by PCP or referred specialist.	1905(a)(29)
Prosthetics	Covered service as recommended by PCP or referred specialist.	1905(a)(12)
<b>EHB Category: Laboratory</b>		
Lab Tests	Covered service as recommended by PCP or referred specialist.	1905(a)(3)
X-Rays	Covered service as recommended by PCP or referred specialist.	1905(a)(3)
Imaging- MRI, CT, and PET	Covered a service as recommended by PCP or referred specialist.	1905(a)(3)
Sleep Studies	Covered service as recommended by PCP or referred specialist.	1905(a)(13)
Diagnostic Genetic Tests	Covered service as recommended by PCP or referred specialist.	1905(a)(13)
Pathology	Covered service as recommended by PCP or referred specialist.	1905(a)(13)
<b>EHB Category: Preventive Care</b>		

Benefit	Description of Amount, Duration and Scope	Reference
Preventive Care Services	Covered service as recommended by PCP or referred specialist. Limited to ACA required preventive services. <sup>4</sup>	1905(a)(13)
Nutritional Counseling	Covered service as recommended by PCP or referred specialist. Only covered related to diabetes education.	1905(a)(29)
Family Planning Services	Covered service.	1905(a)(10)
Vision Care Exams	Covered service.	

**Table 6: Benefits Not Provided**

Benefit	Description of Amount, Duration and Scope	Reference
Acupuncture	Not Covered.	1905(a)(29)
Infertility Diagnoses and Treatment	Not Covered.	1905(a)(29)
Bariatric Surgery	Not Covered.	1905(a)(1)
Hearing Aids	Not Covered.	1905(a)(29)
Vision Services—Eye Glasses	Not Covered.	1905(a)(6)
Nursing Facility Services	Not Covered, except for rehabilitation not to exceed 120 days.	1905(a)(4)
Residential Services	Not Covered.	1905(a)(29)
Non-emergency Transportation Services	Not Covered.	1905(a)(24)
EPSDT	Not Covered.	1905(a)(4)
Other	Any other services not covered by the medical assistance program.	1905(a)(29)

Members who are medically frail will not be mandatorily enrolled in this ABP. Instead, these individuals will be defaulted to enrollment in the Medicaid State Plan. Through the Medicaid State Plan, medically frail individuals will be able to access services including 1915(i) habilitation services and other comprehensive mental health and substance abuse services provided through the Iowa Plan, Iowa's 1915(b) mental health managed care program. Medically frail individuals may opt-out of Medicaid State Plan coverage and receive coverage through the Iowa Wellness Plan ABP, however, wrap around for services available on the Medicaid State Plan but not available on the ABP will not be provided.

### 3.4 Long Term Services and Supports (LTSS) Benefits

Outside of the limited 120 days of nursing facility services, LTSS will not be provided on the Iowa Wellness Plan. Medically frail individuals that need LTSS such as 1915(i) habilitation

<sup>4</sup> 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.

services will be defaulted to enrollment in the Medicaid State Plan and will be able to access these services as appropriate.

### 3.5 Medically Frail

Due to the complexity of medical management and needs, individuals with incomes up to and including 133 percent of the FPL, who meet the definition of medically frail will be defaulted to coverage under the Medicaid State Plan; however, these individuals have the opportunity to opt-out of the Medicaid State Plan coverage and enroll in the Iowa Wellness Plan. To ensure that individuals considered medically frail are not mandatorily enrolled in the ABP, Iowa will implement a multi-tiered screening approach. Consistent with 42 CFR §440.315(f), an individual will be considered medically frail if he or she has any one or any combination of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living; or 5) a determination of disability based on Social Security Administration criteria.

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.
- 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 given a choice of benefit plan and appropriately placed in the Medicaid State Plan or, at the individual's option, placed in the Iowa Wellness Plan.

#### **Section 4: Participant Financial Contribution**

Participant financial contribution under the Iowa Wellness Plan has unique and innovative features designed to encourage utilization of preventive care, overall health promotion, and disease prevention through an incentive based program. During their first year of enrollment, all members are exempted from financial contributions, including copayments for non-emergency use of the emergency department. Starting in the second year of enrollment and coupled with an incentive plan to eliminate monthly contributions, members with income exceeding 50 percent of the FPL will be subject to a monthly required contribution if they did not complete Iowa Wellness Plan targeted preventive or other services in the preceding 12 month enrollment period. However, members who do not complete the healthy behaviors will have the opportunity to request a hardship waiver if they are unable to afford their monthly financial contribution.

Members will be provided 60 days after an incidence of non-payment to pay all outstanding required contributions in full. During the non-payment period, outreach will initiate 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 during this time frame will be terminated from the Iowa Wellness Plan. Individuals terminated from the Iowa Wellness Plan for non-payment of required contributions must then reapply for the Iowa Wellness Plan and go through the eligibility process again to receive coverage.

Members with income below 50 percent of the FPL will not be subject to monthly financial contributions regardless of completion of required services. Beginning in the second year of enrollment, all members will be subject to a \$10 copayment for each non-emergency emergency department visit.

The Iowa Wellness 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 activities which a participant may complete during his or her initial 12 month 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, he or she is exempt from paying monthly contributions in the next 12-month enrollment period. This process is iterative and in each successive 12-month enrollment period, members will have the opportunity to complete activities that will result in exemption from required financial contributions in the subsequent 12-month enrollment period. Under traditional Medicaid, final CMS cost sharing guidelines for individuals with income below 100 percent of the FPL would allow for a cost sharing schedule that includes a \$4 copayment for every outpatient visit, \$75 for an inpatient stay, and \$4 to \$8 per prescription. However, the Iowa Wellness Plan offers members the predictability and certainty that the only financial contributions they are

responsible for is their monthly contribution, which can be eliminated through the completion of healthy behaviors, and any copayments for non-emergency visits to the emergency department.

Although eligible individuals, who have cost-effective ESI coverage, will not be enrolled in the Iowa Wellness Plan and, instead, will receive premium assistance for their ESI coverage through the Iowa 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.

#### 4.1 Participant Financial Contribution Amounts

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 Iowa Wellness Plan. This level of contribution should ensure that members could make their monthly contribution amounts without reaching the federal 5 percent out-of-pocket maximum limit, even if they make copayments for emergency department use. Financial contribution amounts are detailed below in Table 7.

**Table 7: Financial Contributions**

percent of the FPL	Median Income Single		Individual contribution	
	Monthly	Annual	Monthly	Annual
<b>0 percent-50 percent</b>	\$239	\$2,873	\$0	\$0
<b>50 percent-65 percent</b>	\$551	\$6,607	\$10	\$120
<b>65 percent-80 percent</b>	\$694	\$8,330	\$13	\$156
<b>80 percent-100 percent</b>	\$862	\$10,341	\$16	\$192

Financial contributions will be waived the first year of the demonstration. If members complete all required health behaviors during their first year of enrollment, their financial contributions will be waived for their second year of enrollment. For each subsequent year, members will have the opportunity to complete health behaviors to continue to waive their financial contributions. The required health behaviors for the first year of the demonstration will be for members to complete a health risk assessment and obtain a wellness examination from their PCP. Iowa will evaluate and further refine the health behavior requirements for the second year and beyond of the demonstration.

Members, who do not complete the required health behaviors, will be required to pay their financial contributions beginning in the next enrollment year. Members will be provided with the opportunity to request a hardship waiver if they are unable to afford their monthly financial contributions. In addition, members will be provided 60 days after an incidence of non-payment to pay all outstanding required contributions in full. During the non-payment period, outreach will

be initiated 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 during this time frame will be terminated from the Iowa Wellness Plan. Individuals terminated from the Iowa Wellness Plan for non-payment of required contributions must then reapply for the Iowa Wellness Plan and go through the eligibility process again to receive coverage. The termination for non-payment will only impact individuals who do not complete targeted health behaviors and preventive services in the prior year and who are more than 60 days late on payments of their required contributions.

#### 4.2 Copayments

The Iowa Wellness Plan will include \$10 copayments for non-emergency use of the emergency department. This \$10 copayment is waived in the first year of the demonstration and will be implemented in year two. The definition for non-emergency use of the emergency department will 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.

**Table 8: Copayments**

Eligibility Group	Benefit	Copayment Amount
The Adult Group	Non-emergency use of the ED	\$10

#### 4.3 Cost Sharing Exemptions

To prevent members from reaching their 5 percent maximum out of pocket limit, participant financial contributions are indexed to amounts that equate to three percent of income for a household of two enrolled Iowa Wellness Plan members. These contributions are waived in the initial demonstration year, and may be waived thereafter based on completion of targeted health behaviors and preventive services or via a hardship waiver request. After the initial demonstration year, the financial contributions are the only payments for which a participant may be responsible, other than the \$10 copayment for non-emergency use of the emergency department. Table 9 below displays the number of non-emergency visits to the emergency department that a member subject to the required financial contribution would have to make to meet the federal 5 percent of income cost sharing limit.

**Table 9: Median Income and Cost Sharing Estimates and Limits, Single Individual**

Percent of the FPL		0 percent-50 percent	50 percent-65 percent	65 percent-80 percent	80 percent-100 percent
<b>Median Income</b>	Annual	\$2,873	\$6,607	\$8,330	\$10,341
	Monthly	\$240	\$551	\$694	
<b>5 percent of Median Income Limit</b>	Annual	\$144	\$330	\$417	\$517
	Monthly	\$12	\$28	\$35	\$43
<b>Annual Contribution</b>	Annual	\$0	\$120	\$156	\$192
	Monthly	\$0	\$10	\$13	\$16

<b>ED Copayments to Reach 5 percent of Median Income Limit<sup>5</sup></b>	Annual	14	21	26	32
	Monthly	1.2	1.8	2.2	2.7

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 any required payments of monthly financial contributions. This 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 limit if they meet certain qualifying conditions including a change in income or adding or losing a dependent. All household cost sharing amounts for Medicaid programs including required financial contributions and copayments will be included in determining if the member has met their 5 percent out-of-pocket maximum.

#### 4.4 Financial Contribution Justification

Current Medicaid members must pay copayments each time they utilize services, which leads to unpredictable out-of-pocket costs. Provider payments are reduced by the required copayment amount and providers must attempt to collect copayments from members to receive their full compensation. In the Iowa Wellness Plan, payments are predictable and do not change throughout the year, providing stability for members. Members can also earn exemptions from the required contributions through the completion of targeted healthy behaviors and preventive services. In addition, members who cannot afford to pay the contribution will be able to request a hardship exemption. The required contributions in the Iowa Wellness Plan are consistent with the Marketplace Choice Plan and will provide individuals with consistent program policies and prepare them to transition to coverage on the Marketplace Choice Plan or subsidized coverage on the Iowa Marketplace if their FPL increases.

As demonstrated by Table 10 below, financial contributions are less burdensome than allowed under the CMS cost sharing guidelines.

**Table 10: Iowa Wellness Plan Cost Sharing and CMS Cost Sharing Guidelines**

Healthcare Service	CMS Copayment guidelines	Iowa Wellness Plan Member Cost (75 percent of the FPL)	
		Annual	Monthly
Member Yearly Payment	\$0	\$156	\$13
3 Doctor Sick Visits	\$12	\$0	\$0
2 Preferred Prescription	\$96	\$0	\$0

<sup>5</sup> This row shows the number of emergency department visits required to reach the 5 percent of income out of pocket maximum contribution level' it accounts for the required monthly financial contributions and is based on income for a single individual.

Drugs/Month			
Inpatient Visit for Pneumonia	\$75	\$0	\$0
Doctor Visit for Broken Leg	\$4	\$0	\$0
12 Rehab Visits for Broken Leg	\$48	\$0	\$0
<b>Total Member Cost</b>	<b>\$235</b>	<b>\$156</b>	<b>\$13</b>

The Iowa Wellness Plan financial contribution requirement capitalizes on flexibilities currently available and allows the financial incentives to focus on preventive health and long-term program goals. Also, given the members' low-income status, the federal 5 percent out of pocket maximum would result in members reaching their copayment maximum early in the year, with no further financial requirement. Iowa seeks to achieve the policy goal of financial participation through a monthly contribution, rather than a copayment approach, to reinforce the financial responsibility goals of the program. In addition, the collection of copayments is dependent on providers and cannot be enforced by the state Medicaid agency, while the monthly contributions will be enforceable and will ensure that every Iowa Wellness Plan participant will have "skin in the game" and an incentive to invest in his or her health. The monthly contributions are applied to individuals with income 50 percent of the FPL to 100 percent of the FPL and may be waived for the completion of preventive services, health risk assessments, and other targeted healthy behaviors promoted by the Iowa Wellness Plan. In addition, members who do not complete the healthy behavior requirements, have the opportunity to request a hardship waiver if they cannot afford their monthly financial contribution. Analysis indicates the monthly contributions are no more burdensome than CMS cost sharing guidelines and may be waived through member completion of targeted healthy behaviors and preventive services; thus the limitations on premium contributions for the population with income less than 150 percent of the FPL are not applicable for the Iowa Wellness Plan financial contribution requirement.

### **Section 5: Delivery System and Payment Rates for Services**

The Iowa Wellness Plan leverages three different delivery systems and payment methodologies. These delivery systems and associated payment methodologies are summarized in Table 11.

**Table 11: Iowa Wellness Plan Delivery Systems and Payment Methodologies**

Delivery System		PCP		Managed Care
		Independent PCP	PCP in ACO	
Payment Methodology		<ul style="list-style-type: none"> <li>• Fee-for-service</li> <li>• Care coordination payment provided for managing referrals and coordinating care</li> <li>• Incentive bonus payment for members that receive targeted preventive services.</li> <li>• Incentive bonus payments available for achieving quality and process goals.</li> </ul>	<ul style="list-style-type: none"> <li>• Fee-for-service</li> <li>• PCP will receive care coordination payment for managing referrals and coordinating care</li> </ul> <p>Year 1:</p> <ul style="list-style-type: none"> <li>• ACO receives incentive bonuses for members receiving preventive services and for meeting quality and process goals.</li> </ul> <p>Subsequent Years:</p> <ul style="list-style-type: none"> <li>• ACO subject to a risk-adjusted global budget</li> <li>• ACO shared savings based on quality</li> <li>• ACO two-way risk sharing</li> </ul>	<ul style="list-style-type: none"> <li>• Capitation<sup>6</sup></li> </ul>

Providers reimbursed on a fee-for-service basis under the Iowa Wellness Plan will be reimbursed according to the Iowa Medicaid fee schedule. The Iowa Wellness Plan incentivizes PCP coordination of care by allowing PCPs to earn three other types of payment above the fee-for-service payment. PCPs will receive per member per month (PMPM) care coordination payments to coordinate member care and provide referrals. In order to align provider and participant incentives regarding the completion of health behaviors, PCPs may qualify for an additional per member per year bonus based on the completion of wellness exams for a certain percentage of their members. Lastly, PCPs may earn a primary care bonus payment related to improvement in both value and cost. The Iowa Wellness Plan will contract with PCPs in a manner that mirrors the current Medipass agreement.

PCPs who are associated with ACOs will coordinate member care within the context of the ACO organization. The ACO organization will be responsible for coordinating care to generate savings and for reimbursing the associated PCP for quality outcomes. Based upon the fact that there is no baseline data for shared savings, ACOs will be paid, during the first year of the demonstration, on a fee-for-service basis with bonus payments available for quality and coordination of care. After the first year of the demonstration, ACOs will be subject to a risk-adjusted global budget and will be eligible for shared savings based on the achievement of quality metrics. Over the course of the demonstration, aligned with the implementation of the

<sup>6</sup> Capitation will be applicable for HMO, mental health, and dental.

State Innovation Models grant, two sided risk sharing will be implemented for ACOs and they will be at risk for exceeding their budgeted amount.

Actuarially sound capitation rates will be calculated for managed care plans on a PMPM basis.

### 5.1 Delivery System Reforms

One of the main goals of Iowa's efforts around delivery system reform is to assure that coordination of care takes place and that Medicaid members are connected to social services that improve health outcomes. While Iowa's long-term goal, encapsulated by the State Innovation Models grant, is to have complete multi-payor ACO coverage for all Medicaid programs, it will take some time for the Iowa delivery system to fully develop and implement this robust ACO model. To this end, Iowa will leverage all available delivery system models that promote member care coordination and will have different options available to members, depending on geography. When enrolling in the Iowa Wellness Plan, members will have the option of selecting among PCPs, and in locations where available, managed care plans. For members that select a PCP instead of a managed care plan, Iowa will determine if the PCP is associated with an ACO. Thus Iowa Wellness Plan members will have a choice of PCPs and/or managed care plans and may experience one of three different delivery systems: independent PCPs, PCPs associated with ACOs, and managed care plans. Members served by independent PCPs and ACOs will have access to the entire Iowa Medicaid provider network, though PCPs and ACOs may promote appropriate care utilization through referrals, or at ACO discretion with approval from Iowa, provide care to members through a smaller and more coordinated team of providers. Over the course of the demonstration as ACOs develop statewide, a goal is that all members that select the PCP model will be associated with an ACO. Members of the managed care plans will have access to the managed care provider network. Exploring the cost and quality outcomes from these different delivery systems are key lines of inquiry under this demonstration and are key factors in making ACO coverage available for all Medicaid programs.

The main delivery system reform of the Iowa Wellness Plan is to, under all delivery system models, promote coordination of care. Additionally, the Iowa Wellness Plan will work in concert with the State Innovation Models grant to implement ACOs. The ACO phase in will require implementation of risk-adjusted global budgets, shared savings based on achievement of quality metrics, and eventually, two sided risk.

### 5.2 Delivery System Type

The Iowa Wellness Plan has three possible delivery system types. They include Independent PCPs, ACOs, and managed care plans. Services provided by independent PCPs and ACOs will be provided on a fee-for-service basis. Managed care plans will be compensated based on capitation.

For the independent PCPs and ACOs, all enrolled Medicaid providers are eligible to deliver services to members. ACOs and PCPs may use referrals to direct members to appropriate sources of care. PCPs may be eligible to receive incentive payments based on quality and process improvements. ACOs that meet budget targets are eligible to receive shared savings payments if quality metrics are achieved as discussed in Section 5.7.

### 5.3 Accountable Care Organizations

One of the main innovations of the Iowa Wellness Plan is promoting the development of ACOs. Iowa received a State Innovation Models grant to develop a statewide multi-payor ACO model. This model is based on initiatives currently underway in Iowa's commercial market through the Wellmark Blue Cross Blue Shield Model. The Iowa Wellness Plan aligns with the State Innovation Model's goals and will utilize a modified version of the Wellmark Blue Cross Blue Shield ACO model for the Iowa Wellness Plan members served by ACOs.

### 5.4 Provision of Long-term Services and Supports

The 1915(i) Habilitation services will be provided through the Medicaid State Plan and individuals that require these services are considered medically frail and will be defaulted to enrollment in the Medicaid State Plan as detailed in Section 3.5.

### 5.5 Fee-for-Service

For members in the independent PCP or ACO model, all services provided by Iowa Wellness Plan providers will be paid on a fee-for-service basis using the Medicaid State Plan fee schedule. In addition to the fee-for-service payments, ACOs will be eligible to receive shared savings based on a risk adjusted global budget if they meet quality metrics as discussed in Section 5.7 and manage care to keep the total expenditures below their risk-adjusted global budget amount. Independent PCPs will also be eligible for incentive payments based on achievement of quality and/or process goals.

### 5.6 Capitation

Where available, members will have the choice between selection of a primary care physician that may or may not be associated with an ACO, and a managed care plan. Managed care plans will be compensated on an actuarially sound PMPM capitated basis. Managed care plans will not initially be available state-wide, so not all Iowa Wellness Plan members will have access to this option.

Dental benefits and mental health and substance use disorder benefits will be provided as carved out benefits on a contracted basis. Compensation for these benefits will be based on an actuarially sound PMPM capitated basis.

### 5.7 Quality

The Iowa Wellness Plan has a keen focus on quality and all models of care include a quality component. ACOs will be eligible to share in savings generated from care management practices if they meet key quality benchmarks. The Wellmark ACO model, which serves as the foundation for the Iowa Wellness Plan ACO design, includes shared savings payments based on the achievement of quality metrics. Under the Wellmark ACO model, continuous reporting is available to ACOs to promote understanding of patient utilization patterns. The Iowa Wellness Plan will phase in implementation of a similar program that measures both quality and cost. This program may utilize a measure termed the value index score (VIS). Based on the Wellmark model, the VIS is a score that provides an overview of the value of care, enables Iowa to find specific opportunities for improvement, and utilizes current claims data and patient experience to determine a provider's performance. In utilizing patient experience, the VIS takes into account

the patient's level of confidence in the provider's care, continuity of care, office efficiency, and access to care.

ACOs that have successfully managed care and come in under their risk adjusted global budget amount and meet the quality metrics are eligible for shared savings. These 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. Implementation of quality metrics is required within three years of the ACO contracting with the Iowa Wellness Plan. Over the course of the program, based on historical data, additional quality metrics may be added to the Iowa Wellness Plan VIS. To receive the shared savings, ACOs will have to meet the quality targets.

Independent PCPs who coordinate member care will also be eligible to receive incentives based on quality or process goals. Such incentives include a per member per year bonus based on the completion of wellness exams for a certain percentage of their members and a primary care bonus payment related to improvement in both value and cost based upon the PCP's VIS. Quality goals may be related to member outcomes, satisfaction, or completion of targeted preventive services and healthy behaviors. Process goals may include decreasing wait times, improving member adherence to appointments, or improving communication with the Iowa Medicaid Enterprise. These goals and incentive payments will be phased in over the course of the demonstration. Managed care plans will also have quality metrics as part of their contracts.

## **Section 6: Implementation of the Demonstration**

The Iowa Wellness Plan in coordination with the Marketplace Choice Plan will replace the IowaCare 1115 Demonstration waiver, which expires December 31, 2013. Current IowaCare members will be contacted and notified of the new coverage opportunities in 2014. The member outreach and education plan is described in Section 9. Iowa will perform member outreach and education for current IowaCare members and new members about the Iowa Wellness Plan through a third party administrator.

### **6.1 Implementation Schedule**

The Iowa Wellness Plan will be developed throughout 2013 and will replace the IowaCare 1115 Demonstration January 1, 2014. The implementation of the Iowa Wellness Plan coincides with the rollout of the ACA Marketplace and the Iowa Marketplace open enrollment period.

### **6.2 Enrollment**

Current members of the IowaCare 1115 demonstration who meet the Iowa Wellness Plan eligibility criteria will have the opportunity to apply for the Iowa Wellness Plan. These members will be notified of the new program requirements. The members will be screened for access to ESI coverage, and for medically frail status. Eligible individuals with access to cost-effective ESI coverage will be covered through the HIPP program on the Medicaid State Plan. Eligible individuals that are determined to be medically frail will be defaulted into enrollment in the Medicaid State Plan but will be able to opt out into coverage on the Iowa Wellness Plan ABP.

Enrollment in the Iowa Wellness Plan will initiate during the implementation of the ACA's Marketplace. Individuals may apply with the single streamlined application through the Iowa Medicaid Enterprise channels or through the Iowa Marketplace. Coordination between the Marketplace and Medicaid will ensure that individuals who meet the Iowa Wellness Plan requirements are enrolled in the program regardless of whether they apply through Medicaid or the Iowa Marketplace.

During the application process those determined eligible will be screened for medically frail status. Those that are determined to be medically frail will be defaulted to enrollment in Medicaid State Plan coverage, though they will be able to opt-out and receive ABP coverage through the Iowa Wellness Plan. Individuals enrolled in the Iowa Wellness Plan will be provided with the choice to select a PCP or, if available in their location, a managed care plan. Those that select a PCP may end up with an independent PCP or with a PCP that is associated with an ACO; however, it will not be apparent at the point of selection if the selected PCP is associated with an ACO. Members that do not make a selection will have a PCP or managed care plan, as applicable, auto-assigned to them. Once members enroll with a PCP or a managed care plan they will have 90 days to change their selection for any reason. Outside of this 90 period members are expected to remain enrolled with their selected PCP or managed care plan for the remainder of their 12 month enrollment period, unless they experience a qualifying event.<sup>7</sup> The enrollment process is depicted in the enrollment flow detailed on the following page.

Further details on the enrollment of eligible IowaCare members to the Iowa Wellness Plan or Marketplace coverage are included in Section 9.

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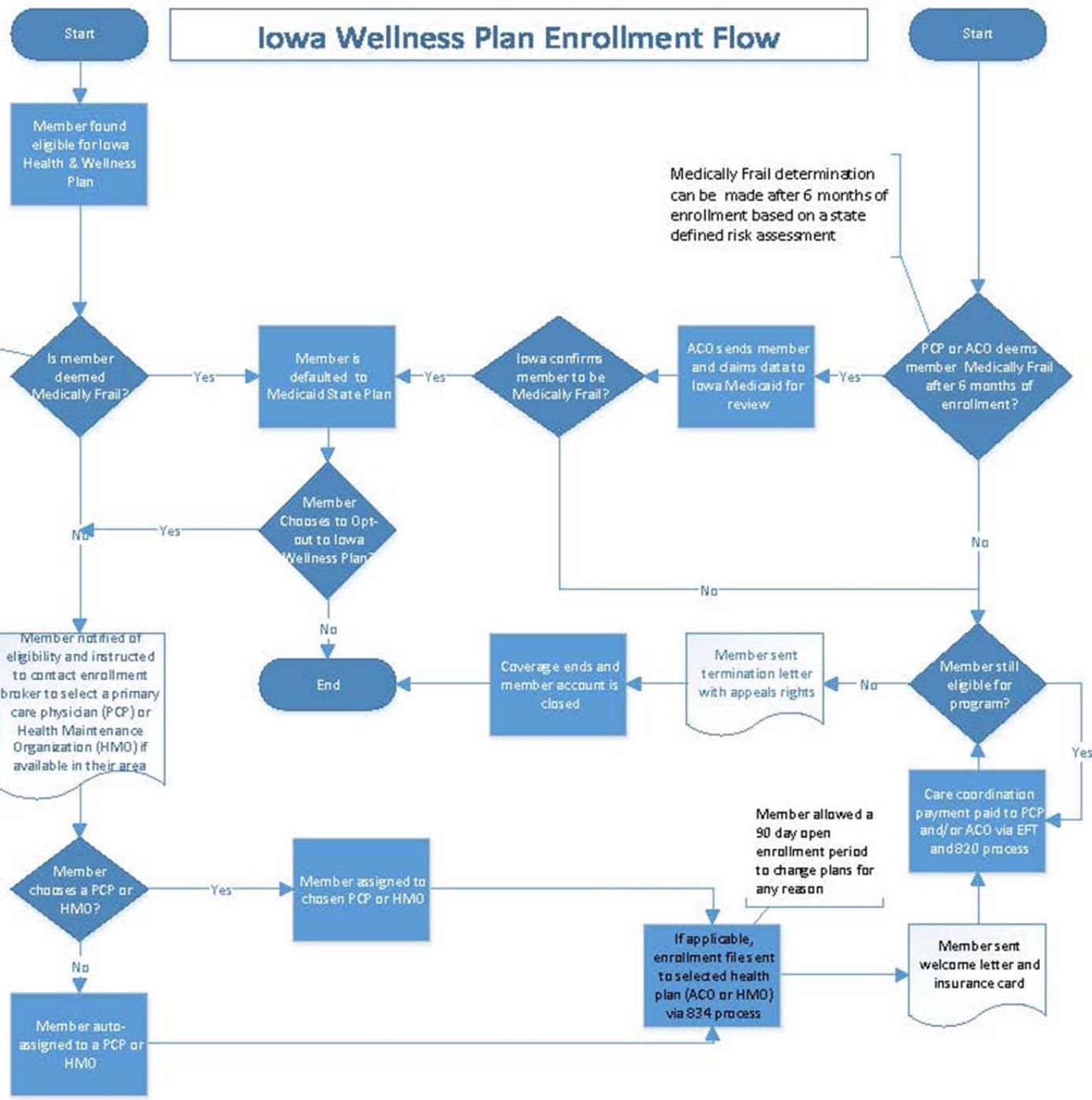
<sup>7</sup> Qualifying events for the Iowa Wellness Plan are the same events that trigger a special enrollment period in the Marketplace.

# Iowa Wellness Plan Enrollment Flow

- 1) disabling mental disorder;
- 2) serious & complex medical condition;
- 3) physical, intellectual, or developmental disability that significantly impairs ability to perform activities of daily living;
- 4) Social Security disability determination;
- 5) a chronic substance abuse disorder

Medically Frail determination can be made after 6 months of enrollment based on a state defined risk assessment

Enrollment Broker will attempt to contact the member if member does not contact the Enrollment Broker



### **6.3 Managed Care**

The Iowa Wellness Plan will contract with managed care plans in locations where they are available. Managed care plans will be compensated on actuarially sound capitated rates and subject to network adequacy and quality requirements. Over the course of the demonstration the Iowa Wellness Plan expects managed care plans to become available across a greater area in the state and expects that some managed care plans may develop ACO components.

Mental health and substance use disorder services and dental services will be provided to Iowa Wellness Plan members as carved out benefits under a contracted managed care model.

### **Section 7: Demonstration Financing and Budget Neutrality**

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

### **Section 8: Federal Medical Assistance percentage**

Pursuant to the Iowa legislation in the Report of the Conference Committee on Senate File 446, implementation of the Iowa Wellness 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 Iowa Wellness 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 Iowa Wellness Plan is modified, IDHS 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 members in the Iowa Wellness Plan 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.

### **Section 9: IowaCare Coordination Plan**

The Iowa Wellness Plan will replace the IowaCare 1115 Demonstration. It is intended as a coverage option for Iowans ages 19 through 64, who do not have access to comprehensive Medicaid, Medicare, or cost-effective ESI coverage and offers coverage to non-medically frail individuals with income up to and including 100 percent of the FPL and medically frail individuals with income up to and including 133 percent of the FPL. The Iowa Wellness Plan eligibility threshold, benefits, delivery system, and payment methodologies differ substantially from the current IowaCare 1115 Demonstration.

The IowaCare 1115 Demonstration expires December 31, 2013; however, through December 31, 2013 currently enrolled members will continue to be eligible for IowaCare covered services.

With the initiation of the open enrollment period in October 2013, the Iowa Medicaid Enterprise will notify all current IowaCare 1115 Demonstration members that the program will expire December 31, 2013. Iowa Medicaid will inform members of their options for health insurance coverage, including the Iowa Wellness Plan, Marketplace Choice Plan and other options

available from the Health Insurance Marketplace. Iowa will follow-up to ensure that all current IowaCare 1115 demonstration members have the opportunity to enroll in a coverage option. .

IowaCare 1115 demonstration members found to be eligible under the new Iowa Wellness Plan eligibility criteria will be enrolled in the Iowa Wellness Plan with coverage effective January 1, 2014. Outreach will be conducted to ensure these individuals understand the differences between Iowa Wellness Plan coverage and their previous IowaCare coverage.

### Section 10: List of Proposed Waivers and Expenditure Authorities

Please see Table 12 below for a description of the waiver authority requests and the rationale for the waiver authority requests for this 1115 waiver application.

**Table 12: Waiver Authority Requests and Rationale**

Waiver Authority and Type	Use for Waiver	Rationale for Waiver Request
§ 1902(a)(1) Statewideness/Uniformity	To the extent necessary, to enable Iowa to operate the Iowa Wellness Plan and provide PCPs, HMOs or PCPs associated with ACOs only in certain geographical areas.	This waiver authority will allow Iowa to implement the utilization of ACOs as they become operational across the State.
§ 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 Iowa Wellness Plan.	The enabling legislation specifies benefits and does not include NEMT. This waiver authority will allow Iowa to align benefits with those specified by the enabling legislation and will also make benefits consistent with those offered to Marketplace Choice Plan members' and Marketplace QHP benefits.
§ 1902(a)(4) Early Periodic Screening, Diagnoses, and Testing (EPSDT)	To exempt Iowa from the requirement to offer EPSDT services to members age 19 and 20 and allow a standard set of benefits for all Iowa Wellness Plan members.	The enabling legislation specifies benefits and does not include EPSDT. This waiver authority will allow Iowa to align benefits with those specified by the enabling legislation and will also make benefits consistent with those offered to Marketplace Choice Plan members' and Marketplace QHP benefits.
§ 1902(a)(10)(B) Amount, Duration, and	To allow Iowa to offer a benefit package to Iowa Wellness Plan	This waiver authority will allow

Waiver Authority and Type	Use for Waiver	Rationale for Waiver Request
Scope of Services	members that differs from the Medicaid State Plan services.	Iowa to align benefits offered to State Employee Plan benefits of the ABP.
§§ 1902(a)(13) & 1902(a)(30) Rate-setting/Payment methodologies	To allow Iowa to test innovative payment methodologies for combining fee-for-service, care coordination, capitation, and cost and quality indexed bonus payments.	This waiver authority will allow Iowa to utilize new payment methodologies with the intended outcome of lowering administrative costs and increasing quality of care and better health outcomes.
§ 1902(a)(14) Cost Sharing Requirements	To allow Iowa to apply the federal 5 percent of income out-of-pocket maximum to be calculated on an annual basis instead of a quarterly basis.	This waiver authority will allow the Iowa Wellness Plan to assess percent of income contributions in alignment with Marketplace policy.
§ 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 aligns the waiver with Iowa Health and Wellness legislation and will test if a copayment of this amount impacts member care seeking behavior and reduces non-emergency ER visits.
§ 1902(a)(23) Freedom of Choice	To allow Iowa to require enrollees select a primary care provider or as available an HMO. To allow Iowa to require enrollees to receive dental services through the carved-out contracted dental benefit and mental health services through the Iowa Plan.	This waiver authority will allow Iowa to require Iowa Wellness Plan members to enroll with a primary care provider or HMO to increase coordination of care and improve health outcomes. And will allow Iowa to require members to receive dental services and mental health and substance use disorder services through the providers offering these benefits as a carve-out.
§ 1902(a)(23) Freedom of Choice	To allow Iowa to require that eligible 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 for ESI covered benefits to those providers	This waiver authority is 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.

Waiver Authority and Type	Use for Waiver	Rationale for Waiver Request
	participating in the cost-effective ESI health plans.	
§ 1902(a)(34) Retroactive Eligibility	To allow Iowa to not offer Iowa Wellness Plan members retroactive eligibility.	The enabling legislation speaks to enrollment as of the first of day of the month following eligibility determination and does not provide for retroactivity. Additionally, this waiver authority will allow Iowa to align with the Marketplace policy and will promote consumer accountability.

### Section 11: Public Comment Period

In completing the Iowa Wellness Plan and Marketplace Choice Plan 1115 demonstration applications, Iowa fully complied with the transparency and public notice requirements. In advance of the comment period and public hearings, Iowa published and abbreviated public notice in the newspapers with the largest circulation in Iowa. The abbreviated notice was also available online. This notice provided the time and location for the two public hearings, a link to the full public comment notice, a web address to the full 1115 waiver documents, and the opening and closing dates of the public comment period. The abbreviated and full public comment notices can be viewed in Appendix 1.

Two hearings were held as scheduled and publicized, one on July 29, 2013, in Des Moines, IA and one on July 30, 2013 in Council Bluffs, IA. Thirteen individuals testified on July 29, and no individuals actually testified on July 30 (asked questions only). A public comment period was open from July 15<sup>th</sup> to August 15<sup>th</sup>. Comments were received in writing, by e-mail, and regular mail. Comments from forty-seven (47) individuals and organizations were received. The below summary includes both the comments offered at the public hearings and via mail or email.

#### 11.1 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.

### 11.2 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.

#### **Section 12: Demonstration Administration**

Name and Title: Jennifer Vermeer, Director

Email Address: JVermee@dhs.state.ia.us

## 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, maternity 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 \$8 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](mailto:DHSIMEHealthandWellnesPlan@dhs.state.ia.us) through **August 15, 2013**. The public, by contacting Maggie Reilly at the above address, may review comments received.

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

### **Iowa Department of Human Services**

#### **Notice of Public Hearing and Public Comment Period**

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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%<sup>8</sup>

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<sup>8</sup> 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.

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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
<b>Total</b>	<b>97,069</b>	<b>118,083</b>	<b>119,854</b>	<b>121,651</b>	<b>123,475</b>

**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
<b>Total</b>	<b>21,788</b>	<b>31,673</b>	<b>32,148</b>	<b>32,630</b>	<b>33,119</b>

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
<b>Wellness Plan</b>						
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
<b>Marketplace Choice Plan</b>						
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
<b>Grand Total</b>	<b>\$883.2</b>	<b>\$1,103.8</b>	<b>\$1,147.6</b>	<b>\$1,193.4</b>	<b>\$1,240.8</b>	<b>\$5,568.8</b>

**BENEFITS**

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

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

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

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

### **PROPOSED HEALTH CARE DELIVERY SYSTEM**

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

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

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

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

### **COST SHARING REQUIREMENTS**

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

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

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

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

### **HYPOTHESES & EVALUATION**

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

- 4) 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 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.
- 5) 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.
- 6) The Iowa Wellness Plan will implement a unique incentive plan to encourage development of cost-conscious consumer behavior in the consumption of health care services and to improve the use of preventive services and other healthy behaviors by waiving required contributions in subsequent enrollment periods for individuals who complete preventive health services, health risk assessments, or other identified services.

The Marketplace Choice Plan will investigate the following research hypotheses.

### **Access**

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

### **Churn**

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

### **Cost**

- Hypotheses:

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

### **Medicaid Service Benefit Wrap**

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

### **Pharmacy**

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

### **Continuity of Care**

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

### **WAIVER & EXPENDITURE AUTHORITIES**

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

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

Iowa Wellness 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](mailto:DHSIMEHealthandWellnesPlan@dhs.state.ia.us) through August 15, 2013. The public, by contacting Maggie Reilly at the above address, may review comments received.



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August 9, 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 Wellness 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 Wellness Plan. The Iowa Wellness Plan 1115 waiver request in concert with the Iowa Marketplace Choice Plan 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 individuals between 19 and 64 years of age with incomes up to and including 100% of the federal poverty level (FPL), and medically frail individuals with incomes up to and including 133% of FPL based on Modified Adjusted Gross Income (MAGI)<sup>1</sup> who are not currently eligible for comprehensive Medicaid or Medicare coverage and without access to cost-effective employer sponsored insurance (ESI) 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 Wellness Plan waiver to the Centers for Medicare and Medicaid

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<sup>1</sup> With the 5% of FPL disregard, individuals with incomes up to and including 138% of FPL may be eligible.

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Services (CMS). The data and information presented may not be appropriate for any other purpose. This letter may not be distributed to any other party without the prior written consent of Milliman, which consent will not be unreasonably withheld. Any distribution of this report must be in its entirety. Any user of this data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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 DHS and its vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data is not complete or is inaccurate, the values presented in our report will need to be reviewed for consistency and adjusted 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.

## **METHODOLOGY AND ASSUMPTIONS**

The State of Iowa is filing two new waiver requests to replace the IowaCare 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 Iowans between the ages of 19 and 64 with incomes up

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to and including 100% of FPL, and medically frail individuals with incomes up to and including 133% of FPL, all of whom do not currently qualify for Medicaid or Medicare and do not have access to cost-effective employer health insurance. The individuals potentially eligible for the Iowa Wellness Plan have three 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. Those with ESI that are determined to be not cost-effective will have access to other coverage options provided under this demonstration.
2. The Iowa Wellness Plan – For individuals at or below 100% of FPL without access to cost-effective ESI coverage, the State will provide a benefit plan that is indexed to the State Employee plan benefits supplemented to include dental services. This plan will utilize an innovative delivery system capitalizing on efficiencies gained through leveraging care coordination through primary care gatekeepers, managed care, and ACOs. Iowa has received a State Innovation Model (SIM) grant to roll-out system wide ACOs, and this demonstration request aligns with the SIM goals.
3. State Plan coverage for medically frail individuals who do not choose to opt out of the Iowa Wellness Plan coverage.

For each Demonstration Year (DY), the following table illustrates the total “Without Waiver”, “With Waiver”, and “Waiver Margin” amounts.

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Iowa Wellness Plan 1115 Waiver Estimated Expenditures				
Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin
2014	1	\$ 591,847,980	\$ 556,602,845	\$ 35,245,135
2015	2	728,212,496	684,326,646	43,885,850
2016	3	757,180,417	711,549,159	45,631,259
2017	4	787,303,342	739,857,140	47,446,202
2018	5	818,609,690	769,276,789	49,332,900
2014 – 2018	DY 1 – 5	\$ 3,683,153,926	\$ 3,461,612,579	\$ 221,541,347

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 Wellness Plan.

2. **Enrollment**

The Iowa Wellness Plan is targeted at the Adult Group, which consists of:

- a. IowaCare members with incomes up to and including 100% of FPL
- b. Currently uninsured individuals with incomes up to and including 100% of FPL

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- c. Individuals without access to cost-effective employer sponsored insurance and incomes up to and including 100% of FPL
- d. Individuals up to and including 100% of FPL that drop individual health coverage (Crowd Out)
- e. Individuals with incomes up to and including 100% of FPL currently enrolled in Iowa's state funded Dependent Persons Program
- f. Medically frail individuals with incomes up to and including 133% of FPL

### **3. Historical Enrollment**

- a. IowaCare up to and including 100% of FPL – The IowaCare enrollment was summarized from the state's eligibility file for each calendar year. Only those with income at or below 100% of FPL were included.
- b. Dependent Persons up to and including 100% of FPL – The enrollment was summarized from the state's eligibility file. Only those with incomes at or below 100% of FPL were included.

### **4. Projected Enrollment**

It is estimated that all of the individuals currently enrolled in the IowaCare and Dependent Persons programs with incomes up to and including 100% of FPL will enroll in the Iowa Wellness demonstration; 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 up to and including 100% of FPL 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 Wellness demonstration will choose not to enroll. Medically frail individuals with incomes up to and including 133% of FPL are assumed to follow the same pattern of enrollment depending on whether they

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are currently enrolled in the IowaCare and Dependent Persons programs or are currently uninsured. It was estimated that 18% of IowaCare and Dependent Persons program eligibles, 7% of uninsured individuals, and 7% of employer-sponsored and individual health insurance insured members can be attributed to the medically frail group. For years 2015 through 2018, enrollment is further projected to increase at a natural growth rate of 1.5%.

#### **5. Historical Costs**

- a. IowaCare up to and including 100% of FPL – Historical IowaCare costs were based on claim files for each of the calendar years. IowaCare is a limited benefit program. Estimated administrative costs were added.
- b. Dependent Persons up to and including 100% 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**

The per member per month (PMPM) calendar year 2014 without waiver healthcare expenditures were estimated to be \$410.41 for the group excluding the medically frail. This amount includes the Medicaid Temporary Assistance for Needy Families (TANF) PMPM increased for mental health, including 1915(i) habilitation rates, remedial services, dental, and pharmacy. The amount was increased for Medicaid administrative expenses using information from the state's budget. The expenditures were projected forward at a combined utilization and cost trend rate of 2.44%, which was calculated using TANF calendar year (CY) 2007-2011 fee for service (FFS) data. The PMPM calendar year without waiver cost for the medically frail was estimated to be \$1,132.64 and was assumed to be equivalent to Iowa's SSI disabled individual cost trended to CY 2014. Note that the IowaCare program's trend rate was assumed not to be credible since IowaCare is a limited benefit program with a limited network. In addition, as the enrollment in the IowaCare program grew from 2007 to 2009, the program had a waiting list for services of up to 8 months.

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## **7. Projected Costs – With Waiver**

The Iowa Health and Wellness demonstration utilizes the Secretary Approved 1937 coverage option for non-medically frail individuals at or below 100% of FPL. Medically frail individuals with incomes up to and including 133% of FPL may opt out of State Plan coverage and access the Secretary Approved 1937 coverage option. All eligible individuals are without cost-effective ESI coverage and are not eligible for comprehensive Medicaid or Medicare coverage. The State's commercial essential health benefit package is slightly richer than the state-employee plan benefits that the Iowa Wellness Plan demonstration will use. As required at 42 CFR 440.315(f), individuals identified as medically frail will not be mandated to enroll in the alternative benefit plan coverage but will be defaulted into coverage under the State Plan and have the option to opt out and enroll in the 1937 coverage option.

Benefits under the Iowa Wellness Plan demonstration for individuals at or below 100% of FPL without access to cost-effective ESI coverage are indexed to the benefits offered through the State Employee plan with dental benefits. 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. All benefits will be provided through the current Iowa Medicaid contracted provider network.

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

With the exception of managed care entities (MCEs), all providers will be compensated on a FFS basis using the State Plan fee schedule. MCEs will be compensated based on actuarially sound capitation rates. Based on a risk-adjusted global budget, ACOs will be eligible to receive shared-savings if they meet quality metrics and manage care to keep the total by region expenditures below the global budget amount. Primary care providers will receive PMPM care coordination payments and will be eligible to receive bonuses based on quality and process goals. MCEs may also have bonus payments for achievement of quality targets built into their contracts.

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Projected “With Waiver” costs are based on the anticipated cost, taking into account the health status of the population. The ACO coverage option “With Waiver” costs assume management of care by the regional ACOs in the state.

### **QUALIFICATION**

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, F.S.A., M.A.A.A.  
Principal & Consulting Actuary

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