Overview: The Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol contains information on the following policies:[1]

1. Premiums or account payments (PR)
2. Health behavior incentives (HB)
3. Retroactive eligibility waivers (RW)
4. Non-eligibility periods (NEP)

Each state with an approved eligibility and coverage demonstration will receive a customized version of the Monitoring Protocol Template that includes each eligibility and coverage policy in its demonstration and the sections applicable for the demonstration overall. If the eligibility and coverage policies are part of a broader section 1115 demonstration, the state should report on the entire demonstration in the sections that apply to all eligibility and coverage demonstrations. In those situations, CMS will work with the state to ensure there is no duplication in the reporting requirements for different policy components of the demonstration. For more information, the state should contact the section 1115 eligibility and coverage demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov), copying the state's CMS demonstration team on the message.

[1] For other eligibility and coverage policies, such as non-emergency medical transportation and marketplace-focused premium assistance, see general guidance for monitoring and evaluation available on Medicaid.gov.

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Iowa.*
Demonstration name	*Iowa Wellness Plan*
Approval period for section 1115 demonstration	*01/01/2020 – 12/31/2024*
Premiums or account payments	
Premiums or account payments start date[a]	*01/01/2020*
Implementation date if different from premiums or account payments start date[b]	Click here to enter text.
Health behavior incentives	
Health behavior incentives start date	*01/01/2020*
Implementation date, if different from health behavior incentives start date	Click here to enter text.
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	*01/01/2020*
Implementation date, if different from retroactive eligibility waiver start date	Click here to enter text.

[a] **Start date:** For monitoring purposes, CMS defines the start date of the demonstration as the "effective date" listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that the effective date of the eligibility and coverage demonstration may differ from the date CMS approved the demonstration.

[b] **Implementation date of policy:** The date the state implemented each eligibility and coverage policy in its demonstration.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in Sections 3, 4, and 5 of the Monitoring Report Template provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information in quarterly and annual monitoring reports (no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☐ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

If a state's monitoring protocol is approved after one or more of its initial quarterly monitoring report submissions, it should report data to CMS retrospectively, for any prior quarters of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. The state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics.

The retrospective report for a state with a first eligibility and coverage demonstration year of less than 12 months, should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the instructions for further guidance determining baseline periods for first eligibility and coverage demonstration years that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Table 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for

instance, the state is not required to describe all metrics changes (+ or -) greater than 2 percent for retrospective reporting periods. Rather, the assessment is an opportunity for the state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not complete renewal and were disenrolled from Medicaid (metric AD_19) over the course of the retrospective reporting period. The state could highlight this change and specify that during this period the state conducted additional outreach to beneficiaries about the renewal process. For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. The state should provide justification for its proposed alternative plan.*

5. Eligibility and coverage demonstration metrics and narrative information

The state should review the guidance in Appendix A of the Monitoring Protocol Instructions in order to attest that it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its section 1115 eligibility and coverage demonstration approval period. This table includes a column for each eligibility and coverage policy in the demonstration. For each eligibility and coverage policy, add details in the corresponding column to indicate the policy demonstration year and quarter for each quarterly monitoring report. Metrics that apply to all eligibility and coverage demonstrations (AD) are expected to be reported starting with the first reporting quarter for the section 1115 eligibility and coverage demonstration, even if it is prior to the implementation of any eligibility and coverage policies. The state is encouraged to discuss with CMS any potential exceptions from this by contacting its CMS demonstration team. The text in the table is an example of how to complete these columns to indicate the measurement period and reporting schedule as it pertains to each eligibility and coverage policy when the policies are being implemented on different time frames. (See detailed table notes for assumptions regarding the demonstration in this example.)

☐ The state has completed the table below according to the guidance in Appendix A of the Monitoring Protocol Instructions and attests to reporting metrics and narrative information in its quarterly and annual monitoring reports according as described.

☐ The state has reviewed Appendix A of the Monitoring Protocol Instructions and completed the table below with the following deviations: *Insert narrative description of proposed changes to reporting. State should provide justification for any proposed deviation.*

Table A. State reporting in quarterly and annual monitoring reports, with example text

Below the table, there are notes that are specific to the example schedule provided. The state should remove any table notes not specific to its reporting schedule.

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
01/01/2020-03/31/2020	DY1Q1	DY1Q1	DY1Q1	DY1Q1	05/29/2020	• Narrative information: AD, PR, and RW DY1Q1 • Monthly and quarterly metrics, no lag: AD, PR, and RW DY1Q1 • Quarterly metrics, 90 day lag: None • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
04/01/2020 – 06/30/2020	DY1Q2	DY1Q2	DY1Q2	DY1Q2	08/29/2020	• Narrative information AD, PR, & RW DY1Q2 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q2 • Quarterly metrics, 90 day lag: AD & HB DY1Q1 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics None

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
07/01/2020 – 09/30/2020	DY1Q3	DY1Q3	DY1Q3	DY1Q3	11/29/2020	• Narrative information: AD, PR, & RW DY1Q3 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q3 • Quarterly metrics, 90 day lag: AD & HB DY1Q2 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
10/01/2020 – 12/31/2020	DY1Q4	DY1Q4	DY1Q4	DY1Q4	03/31/2021	• Narrative information: AD, PR, & RW DY1Q4 • Monthly and quarterly metrics, no lag: AD, RW & PR DY1Q4 • Quarterly metrics, 90 day lag: AD & HB DY1Q3 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: AD DY1 (calculated for DY1)
01/01/2021 – 03/31/2021	DY2Q1	DY2Q1	DY2Q1	DY2Q1	05/30/2021	• Narrative information: AD, PR, RW & HB DY2Q1 • Monthly and quarterly metrics, no lag: AD & PR DY2Q1

Dates of reporting quarter	AD DY	PR DY	HB DY	RW DY	Report due (per STCs schedule)[b]	Measurement period associated with eligibility and coverage information in report, by reporting category
						• Quarterly metrics, 90 day lag: AD & HB DY1Q4 • Annual metrics that are quality of care and health outcomes metrics: None • Other annual metrics: None
04/01/2021 – 06/30/2021	DY2Q2	DY2Q2	DY2Q2	DY2Q2	08/29/2021	• Narrative information: AD, PR, & HB DY2Q2 • Monthly and quarterly metrics, no lag: AD & PR DY2Q2 • Quarterly metrics, 90 day lag: AD & HB DY2Q1 • Annual metrics that are quality of care and health outcomes metrics: AD DY1 (calculated for CY 2019)[c] • Other annual metrics: None

PR = premiums or account payments; HB = health behavior incentives; RW = retroactive eligibility waiver; AD = any demonstration