DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

May 24, 2023

Elizabeth Matney
Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services
1305 E Walnut Street
Des Moines, IA 50319

Dear Ms. Matney:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Eligibility & Coverage (E&C) Monitoring Protocol, which is required by Special Terms and Conditions (STC) # 39 of Iowa's section 1115 demonstration, "Iowa Wellness Plan" (Project No: 11-W-00289/7). CMS has determined that the revised Monitoring Protocol, which was submitted on April 26, 2023, meets the requirements set forth in the STCs and, therefore, approves the state's Monitoring Protocol.

The revised Monitoring Protocol is approved for the demonstration period through December 31, 2024 and is hereby incorporated into the demonstration STCs as Attachment C (see attached). Per 42 CFR 431.424(c), the approved Monitoring Protocol may now be posted to your state's Medicaid website.

We look forward to our continued partnership on the Iowa Wellness Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2023.05.24 11:19:04 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Lee Herko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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Sincerely,

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Lee Herko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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. Community engagement (CE)
4. Retroactive eligibility waivers (RW)
5. 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; CE = community engagement; RW = retroactive eligibility waiver; AD = any demonstration

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Version 3.0)

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration shall complete only one Monitoring Protocol Workbook (Part A) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STC). This state-specific Part A Workbook reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Notes for Iowa Wellness Plan Demonstration

• *At CMS's request, the state of Iowa should use the eligibility and coverage monitoring tools to also report on its Dental Wellness Plan (DWP) component. Iowa should complete the "DWP planned metrics" and "DWP planned subpop" tabs using the standard instructions for the eligibility and coverage demonstration monitoring tools. CMS will provide technical specifications for the state-specific DWP metrics.*

Eligibility and Coverage (EandC)

Note: PRA Disclosure Statement to be added here

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol (Part A) - Planned metrics (AD) (Version 3.0)
State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Any Demonstration (AD)

Standardized information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Adherence with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic*	Data source	Calculation flag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest this planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations**	State plans to phase in reporting (Y/N)	EvalC monitoring report in which metric will be phased in (format: DY#QN e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components, each answers different facets of providing medical assistance with smoking and tobacco use cessation: * Advising smokers and tobacco users to quit * Discussing cessation medications * Discussing cessation strategies	L1.8 Quality of care and health outcomes	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N								
AD_38B	Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	Y	01/01/2020 -12/31/2021	Increase	Increase	Y		N	NA	
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 3488; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: 1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y		N	NA	
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 3489; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y				
AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis. 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence; (2) Opioid abuse or dependence; (3) Other drug abuse or dependence; and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	L1.8 Quality of care and health outcomes	Claims and encounters or EHR	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Increase	Increase	N	The chemical dependency benefit requirement will be excluded from the continuous enrollment criteria. Multiple engagement visits on the same day will not be allowed. Only paid claims are utilized. The process defines the intake period as beginning on the measurement year through 47 days prior to the end of the measurement year. HEDIS states to use the new General Guideline 44 to determine if the ED visit or Observation visit results in an admission. Due to technical constraint and lack of admission details we cannot determine the exact discharge date of the admission. Our logic identifies if the ED Visit or Observation visit is one day prior to the date of the admission to determine if the visit resulted in an inpatient stay. When the initiation event started as an inpatient admission, the engagement events starts the day after discharge. We don't have the full admission event which prevents us identifying the date of discharge; logic will use the last date of service on the claim for the inpatient stay instead of discharge date.	N	NA	
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	L1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	For Obstetric admissions exclusions, will not use MDC Code Admit = 14, and instead use the following Value Sets: Pregnancy. For transfer exclusions, will not use SID A Source = 2,3, will instead add E&F to Point of Origin codes.	N	NA	
AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, healthy behavior incentives, premium assistance, and retroactive eligibility waivers.	L1.9 Administrative cost	Administrative records	None	Demonstration year	Annually	Recommended	N								

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (PR) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Premiums and Account Payments (PR)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b,c]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: PR_21 ***(Do not delete or edit this row)***	*EXAMPLE: Third-party premium payment*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.*	*EXAMPLE: PR.Mod_1: Eligibility and payment amounts*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_2	Beneficiaries who were exempt from premiums for that month	Among beneficiaries enrolled in the demonstration who were subject to the premium (or account contribution) policy on the basis of income or eligibility group, the count of those exempt from owing premiums or other monthly payments, and therefore not required to make payments. For example, demonstration policies may exempt beneficiaries who would otherwise be subject to premiums as incentives for healthy behaviors or other activities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_3	Beneficiaries who paid a premium during the month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid this month.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y		N	NA	
PR_4	Beneficiaries who were subject to premium policy but declare hardship for that month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who were able to claim temporary hardship and were therefore not required to make a payment in the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required if the state allows beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
PR_5	Beneficiaries in short-term arrears (grace period)	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, the number of those who did not pay in the measurement period, but had not yet exceeded their grace period (i.e., allowable period of noncompliance).	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period	Y	01/01/2020-12/31/2020	Decrease	Decrease	Y		N	NA	
PR_6	Beneficiaries in long-term arrears	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who did not pay this month, and who remain enrolled even though they had exceeded the grace period, i.e., allowable period of noncompliance.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a grace period and allows continued enrollment for any income and eligibility groups otherwise subject to premiums once the grace period has been exceeded	N								
PR_7	Beneficiaries with collectible debt	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), number of beneficiaries who had collectible debt.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Decrease	Decrease	N	Iowa will collect this information at the time of application. However, the metric counts cannot be captured after initial enrollment because when the case numbers/ledger keys are in Subject to Recovery status, then there is no way to determine if they had paid the debt or still owe it. They might have paid it in collections or it could have been cancelled after being set to subject to recovery.			
PR_8	Beneficiaries in enrollment duration tier 1	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 1 – the shortest enrollment duration, during which beneficiaries are subject to the first set of program rules and requirements. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_9	Beneficiaries in enrollment duration tier 2	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 2 - the enrollment duration that follows tier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_10	Beneficiaries in enrollment duration tiers 3+	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 3 – the enrollment duration that follows tier 2, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 2. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities. A state with more than three tiers of program rules should calculate additional metrics to report enrollment counts for current enrollees within each additional tier.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended if the state has time-variant premium policies	N								
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	Among beneficiaries enrolled in the demonstration who were not in their renewal month, number of beneficiaries for whom the state processed a change in household size or income during the measurement period and who remained enrolled in the demonstration.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_12	No premium change following mid-year processing of a change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments did not change.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_13	Premium increase following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments increased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_14	Premium decrease following mid-year processing of change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments decreased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of termination for failure to pay	Y	01/01/2020- 12/31/2020	Increase	Increase	Y		N	NA	
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has a non-eligibility period policy	N								
PR_17	Beneficiaries whose benefits are suspended for failure to pay	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay	N								
PR_18	No premium change	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who are redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with no change in premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_19	Premium increase	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with an increase in required premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_20	Premium decrease	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remained in income and eligibility groups subject to the demonstration, with a decrease in required premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N								
PR_21	Third-party premium payment	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	N								
State-specific metrics																	
PR_S1_IA	Beneficiaries who transitioned to basic dental benefits for failure to pay dental premiums	The number of beneficiaries subject to Dental Wellness Plan premiums who transitioned from the full to basic dental benefit package during the measurement period for failure to pay dental premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Reqquired	Y	01/01/2020 -12/31/2020	Decrease	Decrease	Y		N	NA	

[a] The reporting topics correspond to the premiums or account payments (PR) reporting topics in Section 3 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol (Part A) - Planned metrics (HB) (Version 3.0)
State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Healthy Behavior Incentives (HB)

Standardized information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specification manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation flag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specification manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data sources or site-specific definitions, policies, codes, target populations, etc.)[b]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format: DY#QN; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: HB_7 ***(Do not delete or edit this row.)***	*EXAMPLE: Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized healthy behaviors*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period.*	*EXAMPLE: HB Mod_1: Healthy behavior incentives*	*EXAMPLE: Administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2019 - 12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*		
HB_1	Total enrollment among beneficiaries subject to healthy behavior incentive policies who were enrolled in the demonstration at any time during the measurement period.	Number of beneficiaries subject to healthy behavior incentive policies who were enrolled in the demonstration at any time during the measurement period.	HB Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		N	NA	
HB_2	Beneficiaries using incentivized services that can be documented through claims, by service	Total number of beneficiaries enrolled in the demonstration at any point during the measurement period who utilized financially incentivized services that can be documented through claims since the beginning of their enrollment spell.	HB Mod_1: Healthy behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	Unknown at this time due to the Public Health Emergency	We are working with CMS to determine implementation after the Public Health Emergency for all Medicaid and IWP members.
HB_3	Completion of incentivized healthy behavior(s) not documented through claims analysis (i.e. health risk assessments), by healthy behavior	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed each incentivized healthy behavior not documented through claims analysis (i.e. health risk assessments) since the beginning of their enrollment spell.	HB Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2020-12/31/2020	Increase	Increase	Y		N	NA	
HB_4	Completion of all incentivized healthy behaviors (both claims-based and other), if there are multiple	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed all incentivized healthy behaviors (including incentivized services documented through claims and other healthy behaviors not documented through claims) since the beginning of their enrollment spell.	HB Mod_1: Healthy behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		N	NA	
HB_5	Beneficiaries granted a premium reduction for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward related to premium obligations during the measurement period, regardless of whether the premium reduction occurs during the measurement period or in the future.	HB Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides rewards for health incentives in the form of premium reductions	N								
HB_6	Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward other than a premium reduction during the measurement period, regardless of when the reward is realized.	HB Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides financial rewards for health incentives other than in the form of premium reductions	N								
HB_7	Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized healthy behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period.	HB Mod_1: Healthy behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required if the state provides rewards for health incentives in the form of additional covered benefits or services	N								
State-specific metrics																	
[Insert row(s) for any additional state-specific metrics by right-clicking on row 15 and selecting "Insert"]																	

[a] The reporting topic corresponds to the healthy behavior incentives (HB) reporting topic in Section 3 of the monitoring report template.
[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.
[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol (Part A) - Planned metrics (RW) (Version 3.0)
State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Retroactive Eligibility Waiver (RW)

Standardized information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b]	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format: DAHQE; e.g., DY1 Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: RW_1 ***(Do not delete or edit this row.)***	*EXAMPLE: Beneficiaries who indicated that they had unpaid medical bills at the time of application*	*EXAMPLE: The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.*	*EXAMPLE: RW.Mod_1: Retroactive eligibility and demonstration requirements*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020-01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE:*	*EXAMPLE:*
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020-12/31/2020	Consistent	Consistent	Y		N	NA	
RW_2	Beneficiaries who had a coverage gap at renewal	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal process on time.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	N								
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended, and for whom claims were submitted for services rendered during the period of disenrollment that were denied by the state	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	N								
State-specific metrics																	
Insert row(s) for any additional state-specific metrics by right-clicking on row 14 and selecting "Insert"																	

[a] The reporting topic corresponds to the retroactive eligibility waiver (RW) reporting topic in Section 3 of the monitoring report template.
[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.
[c] The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics (DWP) (Version 3.0)
State Iowa
Demonstration Name Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Metrics - Dental Wellness Plan (DWP)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (EandC DY and Q; Format: DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: AD_33 ***(Do not delete or edit this row)***	*EXAMPLE: Preventive care and office visit utilization*	*EXAMPLE: Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period*	*EXAMPLE: 1.1.7 Access to care*	*EXAMPLE: Claims and encounters and other administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE: DY1Q4*	*EXAMPLE:*
State-specific DWP metrics[b]																	
IA_DWP_1	EDV-CH-A: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children [DQA; NQF #2689]	Number of emergency department visits for caries-related reasons per 100,000 member months for children	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_2	EDF-CH-A: Follow-Up after Emergency Department Visits for Dental Caries in Children [DQA; NQF #2695]	The percentage of caries-related emergency department visits among children 0 through 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Recommended	N								
IA_DWP_3	OEV-CH-A: Oral Evaluation, Dental Services [DQA; NQF #2517]	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_4	TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services [DQA; NQF #2528]	Percentage of children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_5	SFM-A-A: Prevention: Sealant Receipt on Permanent 1st Molars	Percentage of enrolled children, who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate	1.1.8 Quality of care and health outcomes	Administrative records; claims and encounters	90 days	Calendar year	Annually	Required	Y								
IA_DWP_6	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_25. It should include DWP related appeals.			
IA_DWP_7	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_26. It should include DWP related grievances.			
IA_DWP_8	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_27. It should include DWP related grievances.			
IA_DWP_9	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services to members <age 21 at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_29. It should include the number of general dentists and pediatric dentists.			
IA_DWP_10	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service to members <age 21 claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_30. It should include the number of general dentists and pediatric dentists.			
IA_DWP_11	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services to members <age 21 at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_31. It should include orthodontists and oral/maxillofacial surgeons providing services to DWP children.			
IA_DWP_12	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services to members <age 21 with service claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y				N	This metric is an adaptation of AD_32. It should include orthodontists and oral/maxillofacial surgeons providing services to DWP children.			

[a] The reporting topics correspond to the prompts for the any demonstration (AD) reporting topic in Section 4 of the monitoring report template.
[b] These metrics are not in the technical specifications manual, instead they are special metrics for which details have been agreed upon by CMS. Please follow general instructions for protocol completion.
End of workbook

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (AD) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Any Demonstration (AD)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	AD_1 - AD_23, AD_33 - AD_44	CMS-provided	Y	N	At or below 50% of the federal poverty level (FPL), 51-100% FPL, 101-133% FPL, and greater than 133% FPL	Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	CMS-provided	Y	Y		Y	
Exempt groups	Eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income *EXAMPLE:* *Geographic exemptions, employer sponsored insurance exemptions, exemptions due to medical frailty*	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	N				
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_44	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	Specific eligibility groups include MAGI and Non-MAGI populations. MAGI populations are new adult group, parents and other caretaker relatives, Transitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligibility who meet income & resource of ease assistance programs, optional eligibility for individuals who would be eligible for cas assistance if they were not in Medical institutions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physical disability, Health and Disability waiver, elderly waiver, intellectual disability waiver, ADS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (PR) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Premiums and Account Payments (PR)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b, c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *PR_1 - PR_21*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	PR_1 - PR_21	CMS-provided	Y	Y		Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	PR_15 - PR_17	CMS-provided	Y	Y		Y	
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	PR_1 - PR_21	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	for the Dental Wellness Plan, the MAGI adult and Non-MAGI adult groups. MAGI groups include populations are new adult group, parents and other caretaker relatives, Transitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligibity who meet income & resource of case assistance programs, optional eligibility for individuals who would be eligible for cas assistance if they were not in Medical institutions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physical disability, Health and Disability waiver, elderly waiver, intellectual disability waiver, ADIS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F= "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (HB) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Healthy Behavior Incentives (HB)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *HB_1 - HB_7*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	HB_1 - HB_7	CMS-provided	Y	Y		Y	
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	HB_1 - HB_7	CMS-provided	Y	Y		Y	
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	HB_1 - HB_7	State-specific	Y		FPL 51 to 100%, FPL 101-133% for IWP, MAGI adult and Non-MAGI adult for Dental Wellness Plan	N	Specific eligibility groups include MAGI and Non-MAGI populations. MAGI populations are new adult group, parents and other caretaker relatives, Transitional Medical Assistance, Pregnant women, former fost care children up to age 26, breast and cervical cancer treatment program. Non-Magi groups are: Mandatory aged, blind & disabled individuals, optional eligiblity who meet income & resource of case assistance programs, optional elgibility for individuals who would be eligible for cas assistance if they were not in Medical institutions, institutionalized individuals, Medicaid for Employed people, 1915(c) HCBS, physical disability, Health and Disability waiver, elderly waiver, intellectual disability waiver, ADIS waiver, brain injury waiver

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F= "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned subpopulations (DWP) (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Dental Wellness Plan (DWP)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N" or grey), list the subpopulations state plans to report (Format comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Specific demographic groups	Age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)	Required	IA_DWP_1-IA_DWP_4	State-specific	Y		The state should report all DWP planned metrics (IA_DWP_1-IA_DWP_4) for DWP children by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20)		
Specific demographic groups	Geographic region	Recommended	IA_DWP_1-IA_DWP_14	State-specific	Y		The state should report all DWP planned metrics (IA_DWP_1-IA_DWP_5) and DWP adaptations of AD metrics (IA_DWP_6-IA_DWP_14) by geographic region.		

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.
[b] If applicable. See CMS-provided technical specifications on subpopulation categories.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 3.0)

State: Iowa
Demonstration Name: Iowa Wellness Plan

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the eligibility and coverage demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the eligibility and coverage demonstration reporting schedule table (Table 2). For each of the reporting categories listed in columns E and F, select Y or N in the "Deviation from standard reporting schedule (Y/N)" column to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category, the state should describe these deviations in the "Explanation for deviations" column and use the "Proposed deviations from standard reporting schedule" column to indicate the measurement periods with which it wishes to overwrite the standard schedule. All other columns are locked for editing and should not be altered by the state.

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates			
	AD	PR	HB	RW
Dates of first demonstration year				
Start date (MM/DD/YYYY)	01/01/2020	01/01/2020	01/01/2020	08/01/2020
End date (MM/DD/YYYY)	12/31/2020	12/31/2020	12/31/2020	12/31/2020
Dates of first quarter of the baseline reporting period for CMS-constructed metrics				
Reporting period (EandC DY and Q) (Format DY#Q#; e.g. DY1Q1)	DY1Q1	DY1Q1	DY1Q1	DY1Q1
Start date (MM/DD/YYYY)[a]	01/01/2020	01/01/2020	01/01/2020	08/01/2020
End date (MM/DD/YYYY)	03/31/2020	03/31/2020	03/31/2020	08/31/2020
Broader section 1115 demonstration reporting period corresponding with the first EandC reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY#Q#; e.g. DY1Q3)	DY1Q1	DY1Q1	DY1Q1	DY1Q1
First monitoring report due date (per SICs) (MM/DD/YYYY)	05/31/2020	05/31/2020	05/31/2020	05/31/2020
First monitoring report in which the state plans to report calendar year (CY) metrics with a 90 day lag				
Reporting period (Format CY#; e.g. CY2019)	CY2020			
DY and Q associated with monitoring report (Format DY#Q#; e.g. DY1Q1)	DY2Q3			
DY and Q start date (MM/DD/YYYY)	07/01/2021			
DY and Q end date (MM/DD/YYYY)	09/30/2021			
Dates of last reporting quarter:				
Start date (MM/DD/YYYY)	10/01/2024	10/01/2024	10/01/2024	10/01/2024
End date (MM/DD/YYYY)	12/31/2024	12/31/2024	12/31/2024	12/31/2024

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	PR	HB	RW	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD	PR	HB	RW
01/01/2020	03/31/2020	05/31/2020	DY1Q1	None	Narrative information	DY1Q1	DY1Q1	DY1Q1	DY1Q1						
				30 days	Month	DY1Q1	DY1Q1		DY1Q1						
				None	Quarter	DY1Q1				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY1Q1.				
				90 days	Quarter										
				90 days	Calendar year										
				None	Demonstration year										
04/01/2020	06/30/2020	08/29/2020	DY1Q2	None	Narrative information	DY1Q2	DY1Q2	DY1Q2	DY1Q2						
				30 days	Month	DY1Q2	DY1Q2		DY1Q2						
				None	Quarter	DY1Q2				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY1Q2.				
				90 days	Quarter	DY1Q1		DY1Q1	DY1Q1	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY1Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2020	09/30/2020	11/29/2020	DY1Q3	None	Narrative information	DY1Q3	DY1Q3	DY1Q3	DY1Q3						
				30 days	Month	DY1Q3	DY1Q3		DY1Q3						
				None	Quarter	DY1Q3				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY1Q3.				
				90 days	Quarter	DY1Q2		DY1Q2	DY1Q2	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 DY1Q2.				
				90 days	Calendar year										
				None	Demonstration year										
10/01/2020	12/31/2020	03/31/2021	DY1Q4	None	Narrative information	DY1Q4	DY1Q4	DY1Q4	DY1Q4						
				30 days	Month	DY1Q4	DY1Q4		DY1Q4						
				None	Quarter	DY1Q4				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY1Q4.				
				90 days	Quarter	DY1Q3		DY1Q3	DY1Q3	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY1Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY1									
01/01/2021	03/31/2021	05/30/2021	DY2Q1	None	Narrative information	DY2Q1	DY2Q1	DY2Q1	DY2Q1						
				30 days	Month	DY2Q1	DY2Q1		DY2Q1						
				None	Quarter	DY2Q1				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY2Q1.				
				90 days	Quarter	DY1Q4		DY1Q4	DY1Q4	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY1Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2021	06/30/2021	08/29/2021	DY2Q2	None	Narrative information	DY2Q2	DY2Q2	DY2Q2	DY2Q2						
				30 days	Month	DY2Q2	DY2Q2		DY2Q2						
				None	Quarter	DY2Q2				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY2Q2.				
				90 days	Quarter	DY2Q1		DY2Q1	DY2Q1	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY2Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2021	09/30/2021	11/29/2021	DY2Q3	None	Narrative information	DY2Q3	DY2Q3	DY2Q3	DY2Q3						
				30 days	Month	DY2Q3	DY2Q3		DY2Q3						
				None	Quarter	DY2Q3				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY2Q3.				
				90 days	Quarter	DY2Q2		DY2Q2	DY2Q2	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY2Q2.				
				90 days	Calendar year	CY2020				Y	The state should additionally report 1A_DWP_1 - 1A_DWP_5 in CY2020.				
				None	Demonstration year										
10/01/2021	12/31/2021	03/31/2022	DY2Q4	None	Narrative information	DY2Q4	DY2Q4	DY2Q4	DY2Q4						
				30 days	Month	DY2Q4	DY2Q4		DY2Q4						
				None	Quarter	DY2Q4				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY2Q4.				
				90 days	Quarter	DY2Q3		DY2Q3	DY2Q3	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY2Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY2									
01/01/2022	03/31/2022	05/30/2022	DY3Q1	None	Narrative information	DY3Q1	DY3Q1	DY3Q1	DY3Q1						
				30 days	Month	DY3Q1	DY3Q1		DY3Q1						
				None	Quarter	DY3Q1				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY3Q1.				
				90 days	Quarter	DY2Q4		DY2Q4	DY2Q4	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY2Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2022	06/30/2022	08/29/2022	DY3Q2	None	Narrative information	DY3Q2	DY3Q2	DY3Q2	DY3Q2						
				30 days	Month	DY3Q2	DY3Q2		DY3Q2						
				None	Quarter	DY3Q2				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY3Q2.				
				90 days	Quarter	DY3Q1		DY3Q1	DY3Q1	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY3Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2022	09/30/2022	11/29/2022	DY3Q3	None	Narrative information	DY3Q3	DY3Q3	DY3Q3	DY3Q3						
				30 days	Month	DY3Q3	DY3Q3		DY3Q3						
				None	Quarter	DY3Q3				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY3Q3.				
				90 days	Quarter	DY3Q2		DY3Q2	DY3Q2	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY3Q2.				
				90 days	Calendar year	CY2021				Y	The state should additionally report 1A_DWP_1 - 1A_DWP_5 in CY2021.				
				None	Demonstration year										
10/01/2022	12/31/2022	03/31/2023	DY3Q4	None	Narrative information	DY3Q4	DY3Q4	DY3Q4	DY3Q4						
				30 days	Month	DY3Q4	DY3Q4		DY3Q4						
				None	Quarter	DY3Q4				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY3Q4.				
				90 days	Quarter	DY3Q3		DY3Q3	DY3Q3	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY3Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY3									
01/01/2023	03/31/2023	05/30/2023	DY4Q1	None	Narrative information	DY4Q1	DY4Q1	DY4Q1	DY4Q1						
				30 days	Month	DY4Q1	DY4Q1		DY4Q1						

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	PR	HB	RW	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD	PR	HB	RW
				None	Quarter	DY4Q1				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY4Q1.				
				90 days	Quarter	DY3Q4		DY3Q4	DY3Q4	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY3Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2023	06/30/2023	08/29/2023	DY4Q2	None	Narrative information	DY4Q2	DY4Q2	DY4Q2	DY4Q2						
				30 days	Month	DY4Q2	DY4Q2		DY4Q2						
				None	Quarter	DY4Q2				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY4Q2.				
				90 days	Quarter	DY4Q1		DY4Q1	DY4Q1	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY4Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2023	09/30/2023	11/29/2023	DY4Q3	None	Narrative information	DY4Q3	DY4Q3	DY4Q3	DY4Q3						
				30 days	Month	DY4Q3	DY4Q3		DY4Q3						
				None	Quarter	DY4Q3				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY4Q3.				
				90 days	Quarter	DY4Q2		DY4Q2	DY4Q2	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY4Q2.				
				90 days	Calendar year	CY2022				Y	The state should additionally report 1A_DWP_1 - 1A_DWP_5 in CY2022.				
				None	Demonstration year										
10/01/2023	12/31/2023	03/30/2024	DY4Q4	None	Narrative information	DY4Q4	DY4Q4	DY4Q4	DY4Q4						
				30 days	Month	DY4Q4	DY4Q4		DY4Q4						
				None	Quarter	DY4Q4				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY4Q4.				
				90 days	Quarter	DY4Q3		DY4Q3	DY4Q3	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY4Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY4									
01/01/2024	03/31/2024	05/30/2024	DY5Q1	None	Narrative information	DY5Q1	DY5Q1	DY5Q1	DY5Q1						
				30 days	Month	DY5Q1	DY5Q1		DY5Q1						
				None	Quarter	DY5Q1				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY5Q1.				
				90 days	Quarter	DY4Q4		DY4Q4	DY4Q4	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY4Q4.				
				90 days	Calendar year										
				None	Demonstration year										
04/01/2024	06/30/2024	08/29/2024	DY5Q2	None	Narrative information	DY5Q2	DY5Q2	DY5Q2	DY5Q2						
				30 days	Month	DY5Q2	DY5Q2		DY5Q2						
				None	Quarter	DY5Q2				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY5Q2.				
				90 days	Quarter	DY5Q1		DY5Q1	DY5Q1	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY5Q1.				
				90 days	Calendar year										
				None	Demonstration year										
07/01/2024	09/30/2024	11/29/2024	DY5Q3	None	Narrative information	DY5Q3	DY5Q3	DY5Q3	DY5Q3						
				30 days	Month	DY5Q3	DY5Q3		DY5Q3						
				None	Quarter	DY5Q3				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY5Q3.				
				90 days	Quarter	DY5Q2		DY5Q2	DY5Q2	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY5Q2.				
				90 days	Calendar year	CY2023				Y	The state should additionally report 1A_DWP_1 - 1A_DWP_5 in CY2023.				
				None	Demonstration year										
10/01/2024	12/31/2024	03/31/2025	DY5Q4	None	Narrative information	DY5Q4	DY5Q4	DY5Q4	DY5Q4						
				30 days	Month	DY5Q4	DY5Q4		DY5Q4						
				None	Quarter	DY5Q4				Y	The state should additionally report 1A_DWP_6 - 1A_DWP_10 in DY5Q4.				
				90 days	Quarter	DY5Q3		DY5Q3	DY5Q3	Y	The state should additionally report 1A_DWP_11 - IA_DWP_14 in DY5Q3.				
				90 days	Calendar year										
				None	Demonstration year	DY5									
[Add rows for all additional demonstration reporting quarters]															

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the 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 that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "EandC reporting schedule tab" should align with the first day of a month. If a state's eligibility and coverage demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "EandC reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.