DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL - 1 2005

Mr. Kevin Concannon
Director
Iowa Department of Human Services
1305 E. Walnut Street
Des Moines, IA 50319-0114

Dear Mr. Concannon:

We are pleased to inform you that the Iowa section 1115 Medicaid demonstration project, entitled IowaCare (Project No. 11-W-00189/7) has been approved for a 5 year period, from July 1, 2005, through June 30, 2010, in accordance with section 1115(a) of the Social Security Act (the Act).

Our approval of the IowaCare 1115(a) demonstration project, including the expenditure authorities provided thereunder, are conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and the extent of Federal involvement in the demonstration. The STCs are effective July 1, 2005, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the IowaCare demonstration.

The Department of Health and Human Services' approval of IowaCare, including the associated expenditure authorities, is contingent upon compliance with the enclosed list of STCs.

The following list summarizes the negotiated components of the demonstration project.

<u>Expansion Population</u>
Iowa will provide a limited set of Medicaid benefits to adults ages 19 through 64, including parents of Medicaid and SCHIP-eligible children, using a provider network at the University of Iowa Hospitals and Broadlawns Hospital. Enrollees will be required to pay monthly premiums not to exceed 5 percent of annual family income.

<u>Home and Community-Based Waiver for Seriously Emotionally Disabled Children</u>
Iowa will incorporate home and community-based services for children diagnosed with chronic mental illness. These children will receive full Medicaid State plan services as well as supportive services in the community. This will enable children who would otherwise be served in inpatient facilities to remain with their families in the community. Although authority is granted under section 1115(a), this program will operate using the principles of home and community-based waivers.

Payment Reform
Iowa will cease the financing arrangements which inappropriately obtain Federal financial participation (FFP) for its Medicaid State plan and agrees not to implement any new provider taxes for the duration of the demonstration.

Mental Health Transformation Pilot
The FFP will be permitted in a limited amount for services rendered through the Mental Health Transformation Pilot. This expenditure authority is granted only as a "stop gap" measure to maintain current Federal funding levels to ensure proper care to the State's vulnerable populations. We expect that prior to applying for a renewal of this waiver, the State will have planned alternatives to this funding approach.

Budget Neutrality
The demonstration is approved with an aggregate budget neutrality limit of $587.7 million total computable for the 5 years of the demonstration. The management of your program within the approved budget cap is essential in order to successfully meet the terms of budget neutrality for the demonstration project.

Implementation Plan
Iowa will be required to provide an Implementation Plan to implement the provisions of this waiver.

Evaluation
Iowa will be required to conduct an evaluation of the impact of all facets of the demonstration program during the approval period.

A full listing of the approved expenditure authorities for the demonstration is enclosed.

We commend the State for your interest in providing long-term care services consistent with the President's New Freedom Initiative and in support of the Olmstead ruling. We are commited to working with you on State plan amendment 05-012, with a requested effective date of July 1, 2005. Our mutual goal is to design and implement a program that will improve the management of and access to community services in a manner that will ensure beneficiaries' access to high quality and cost-effective care.

Written notification to our office of your acceptance of this award must be received within 30 days after you receive this letter. Your project officer is Mr. Stephen Hrybyk. He is available to answer any questions concerning this demonstration project. Mr. Hrybyk's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Mailstop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1058
Facsimile: (410) 786-5882
E-mail: Stephen.Hrybyk@cms.hhs.gov

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Official communications regarding program matters should be sent simultaneously to Mr. Hrybyk and to Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Kansas City Regional Office. Mr. Scott's address is:

Center for Medicare & Medicaid Services
Division of Medicaid & Children's Health
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106

If you have questions regarding this approval, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at 410-786-5647.

Again, congratulations on the approval of your section 1115 demonstration. We are also enclosing your HCFA-179, at your request. We look forward to continuing to work with you and your staff.

Sincerely,

Mark B. McClellan, M.D., Ph.D.

Enclosures

Expenditure Authorities for Iowa's IowaCare Demonstration

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration, be regarded as expenditures under the State's Title XIX Plan. All requirements of the Medicaid statute shall be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed Special Terms and Conditions will apply to these expenditure authorities.

1. **Demonstration Population 1:** Expenditures for services provided to:
    - Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or any other waiver except the Family Planning waiver under Title XIX; and
    - Parents whose incomes between 0 and 200 percent of the FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, who are not otherwise Medicaid eligible.

2. **Demonstration Population 2:** Expenditures for obstetrical and newborn care provided to newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses of all family members that reduce available family income to 200 percent of the FPL.

3. **Demonstration Population 3:** Expenditures for services provided to children from birth to age 18 who have serious emotional disabilities and who:
    - Would be eligible for State Plan services if they were in a medical institution; and
    - Need home and community-based services in order to remain in the community;

    And who:

    - Have income at or below 300 percent of the SSI Federal benefit; or
    - Have net family income at or below 250 percent of the FPL for family size.

4. **Demonstration Expanded Services 1:** Expenditures for services not otherwise covered under the Medicaid State plan that are comparable to the services provided to Demonstration Population 1, and are provided to individuals in eligibility groups receiving only limited benefits under the Medicaid State plan.

5. **Demonstration Expanded Services 2:** Expenditures for care and services furnished by or through the Department of Human Services under the Mental Health Transformation Pilot

that would not otherwise be covered under Title XIX or this demonstration will be capped at the following amounts for each year of the demonstration.

DY	Annual Limit on Expenditures for Demonstration Expanded Services 2
FFY 2006	$26 million
FFY 2007	$26 million
FFY 2008	$26 million
FFY 2009	$9 million
FFY 2010	$0

Exceptions to Medicaid Requirements for Demonstration Populations & Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration populations and services except for the following:

Methods of Administration: Transportation — 1902(a)(4) and 42 CFR 431.50

The State is not required to assure transportation to and from providers for Demonstration Populations 1 and 2.

Eligibility Procedures — 1902(a)(10)(A) and 1902(a)(10)(C)(I)-(III)

The State may use streamlined eligibility procedures for Demonstration Populations 1 and 2.

Redetermination — 1902(a)(19) and 42 CFR 435.930(b)

The State is not required to send notice of renewal of enrollment in IowaCare to beneficiaries at the end of twelve months.

Comparability — 1902(a)(10)(B)

The State may offer different benefits to Demonstration Populations.

Cost-sharing and Premiums — 1902(a)(14)

The State may charge premiums for Demonstration Populations 1 and 2.

Financial Responsibility/Deeming — 1902(a)(17)(D)

The State may consider the income of family members other than a spouse or parent in determining eligibility for Demonstration Populations 1 and 2.

Freedom of Choice 1902(a)(23)

The State may limit freedom of choice of provider for Demonstration Populations 1 and 2.

Retroactive Eligibility 1902(a)(34)

The State is not required to provide services to Demonstration Populations 1 and 2 for any time prior to when an application for IowaCare is made.

Early and Periodic Screening, Diagnostic, and Treatment Services 1902(a)(43)

The State is not required to provide coverage of early and periodic screening, diagnostic, and treatment services to 19 and 20 year-old members of Demonstration Populations 1 and 2.

Income & Eligibility Verification 1902(a)(46)

The State may accept self-attestation as proof of income for IowaCare eligibility determinations for Demonstration Populations 1 and 2.

Disenrollment for Non-Payment of Premiums 1916(c)(3)

The State may disenroll individuals in Demonstration Populations 1 and 2 after providing notice of such disenrollment for failure to pay premiums without requiring the failure to continue for sixty days. Beneficiaries will have access to a fair hearing process to appeal the disenrollment.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00189/7

TITLE: IowaCare Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Iowa's IowaCare section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Iowa Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for the five-year period, from July 1, 2005 through June 30, 2010. The special terms and conditions set forth below and the list of expenditure authorities are incorporated in their entirety into the letter approving the Demonstration.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Reimbursement and Finance; Operational Issues; and Evaluation.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, & Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Changes in Law.** The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such

changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall be required to submit Title XIX State plan amendments for reimbursement methodologies affecting any populations covered solely through the Demonstration. However, the State shall not be required to submit Title XIX State plan amendments for benefits and eligibility changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, Federal financial participation, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list within 60 days of the approval of the Demonstration renewal that shall contain all elements of the Demonstration that are subject to the amendment process. Amendments to the Demonstration shall not apply before the effective date.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 90 days prior to the date of implementation. Amendment requests as specified above shall include the following:

   a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   b) A current assessment of the impact the requested amendment shall have on budget neutrality;
   c) An explanation of how the amendment is consistent with the overall principles and objectives of the Demonstration;
   d) A description of how the evaluation design shall be modified to incorporate this amendment request.

8. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State shall submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline

shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant costs not otherwise matchable are suspended by the State, CMS shall be liable for only normal close-out costs.

9. **Enrollment Limitation.** During the last six months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the Demonstration is extended by CMS.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs.

12. **Adequacy of Infrastructure.** The State shall insure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

13. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration, including, but not limited to, those referenced Section II, paragraph 6 and Section IX are proposed by the State.

14. **Federal Funds Participation.** No Federal matching for expenditures for this Demonstration will take effect until the implementation date.

III. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to health care delivery, enrollment, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

16. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include:

    a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
    b) Action plans for addressing any policy and administrative issues identified.
    c) Enrollment data including the number of persons in each Demonstration Population served under the waiver.
    d) Budget neutrality monitoring tables.
    e) Progress on the IowaCare implementation plan.
    f) Other items as requested.

17. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

18. **Annual Program Compliance Evaluation.** The State shall submit an annual evaluation documenting Iowa medical assistance program compliance with each of the following:
    - That the state has not instituted any new provider taxes governed by 1903(w) of the Social Security Act (hereinafter "the Act").
    - That providers retain 100 percent of the total computable payment of expenditures claimed under Title XIX of the Act.
    - That government-operated hospitals and nursing facilities are not paid more than the actual costs of care for medical care and medical education based upon relevant Medicaid statutory and regulatory provisions as well as the approved Medicaid State plan.
    - That expenditures claimed under Title XIX of the Act for the Mental Health Transformation Pilot are expended for Demonstration Expanded Services 2 (as defined in item 4.b. of Attachment A).

IV. ELIGIBILITY, ENROLLMENT AND BENEFITS

19. **Demonstration Populations.** The following populations are included in the Demonstration:

    a) <u>**Demonstration Population 1**</u> **(Expansion Population)** includes the following:
        i) Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; and
        ii) Parents whose incomes between 0 and 200 percent of the FPL is considered in

determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.

b) **Demonstration Population 2 (Spend-Down Pregnant Women)** includes newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses for all family members that reduce available family income to 200 percent of the FPL.

c) **Demonstration Population 3 (Seriously Emotionally Disabled Children)** includes children from birth to age 18 who have serious emotional disorders and:
- Would be eligible for State Plan services if they were in a medical institution; and
- Who need home and community-based services in order to remain in the community;

And who:
- Have income at or below 300 percent of the SSI Federal benefit; or
- Have net family income at or below 250 percent of the FPL for family size.

Children who are being served on June 30, 2005 through the State foster care system and meet the eligibility criteria shall be given first priority for enrollment in the Demonstration.

20. **Enrollment Cap.** The State reserves the right to limit the Demonstration Population 1 and 2 to those who are first to apply. However, any limitation for these populations must be submitted to CMS for review and approval following the process outlined in Special Term and Condition 6.

21. **Benefits and Coverage for Demonstration Populations 1 and 2.** The benefits and coverage for these populations shall be limited to inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies and transportation services to the extent that these services are covered by the Medicaid State plan. All conditions of service provision will apply in the same manner as under the Medicaid State plan including, but not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be medically necessary.

22. **Benefits and Coverage for Demonstration Population 3.** In addition to all the benefits offered under the Medicaid State plan, the individuals in Demonstration Population 3 shall be eligible for the following benefits:

a) **Case Management.** Services that will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case management services may not include the administration of the State's foster care program. Case managers must meet the State's provider qualifications and may include any willing provider.

b) **Respite Care.** Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Services will be provided in the following settings: Individual's home or place of residence; Foster home; Medicaid certified hospital; Medicaid certified NF; Medicaid certified ICF/MR; Group home; Adult Day Care Center; Assisted Living; Camp; or Child Care Facility.

c) **Environmental Modifications and Adaptive Devices.** Items installed or utilized within the child's home that respond to specific documented health and safety concerns. Items may include, but are not limited to, smoke alarms, window/door alarms, pager supports and fencing.

d) **In Home Family Therapy.** Skilled therapeutic services provided to the child and the family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and their familial relationships. The service will support the family by the development of coping strategies that will enable the child to continue living within the family environment.

e) **Family and Community Support Services.** This service shall be provided under the recommendation and direction of the mental health professionals that are included in the child's interdisciplinary team. These professionals in conjunction with the other members of the interdisciplinary team shall mutually identify interventions that will assist the child and family in the development of skills related to stress reduction, management of depression, and psychosocial isolation.

The service provider shall incorporate the mutually identified interventions into the service components that may include the following:

i) Development of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management and maintenance of the home environment);
ii) Development of positive socialization and citizenship skills in the community while engaging in community activities; and
iii) Development of a crisis support network.

The Family and Community Support Services service may include an amount not to exceed $1,500.00 annually per child for Individual Support Needs, which may include the following:

i) Transportation within the community excluding medical transportation which is included under the State Plan; and
ii) Therapeutic resources that may include books, training packages, and visual or audio media as recommended by the interdisciplinary mental health professionals. The therapeutic resources are the property of the child and/or family.

The hierarchy for payment of Individual Support Needs is as follows:

i) The child's family or legal representative
ii) Community resources

iii) Durable Medical Equipment or Supplies (Medicaid State Plan)
iv) Individual Support Needs

The following are specifically excluded from Medicaid payment for In Home Family Therapy and Family and Community Support Services:
i) Vocational Services
ii) Prevocational Services
iii) Supported Employment Services, and
iv) Room and board

Benefits and coverage provided to Demonstration Population 3 will be operated under the principles of a home and community-based services waiver.

V. COST SHARING

23. Premiums may be charged to individuals in Demonstration Populations 1 and 2 as follows:

Population	Premiums
• Individuals ages 19 through 64 with family incomes between 0 and 100 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; • Parents whose incomes between 0 and 100 percent of FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.	No more than one-twelfth of two percent of the individual's annual family income
• Individuals ages 19 through 64 with family incomes between 100 and 200 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; • Parents whose incomes between 100 and 200 percent of FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible .	No more than one-twelfth of five percent of the individual's annual family income

VI. DELIVERY SYSTEMS

24. **Provider Network.** The provider network serving Demonstration Populations 1 and 2 includes government-operated acute care teaching hospitals and the University of Iowa Hospitals and Clinics.

Demonstration Population 2 may also receive obstetric and newborn services from any Medicaid-certified provider, unless the beneficiary resides in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties, in which case the beneficiary must receive obstetric and newborn services from the University of Iowa

Hospitals and Clinics.

Demonstration Population 3 may use all Medicaid-certified providers rendering the services outlined in Attachment D.

VII. GENERAL FINANCIAL REQUIREMENTS

25. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Attachment B (Monitoring Budget Neutrality for the Demonstration).

26. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) In order to track expenditures under this Demonstration, Iowa shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered). Corrections for any incorrectly reported Demonstration expenditures for previous Demonstration years must be input within three months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2c.

    b) For each Demonstration year, Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures subject to the budget neutrality cap. The State must complete separate forms for each Demonstration Population: 1) Expansion Population 2) Spend-down Pregnant Women, and 3) Seriously Emotionally Disabled Children. The forms for each Demonstration Population must reflect expenditures net of Demonstration Expansion Services. The sum of the quarterly expenditures for the three population categories and Demonstration Expansion Services for all Demonstration years shall represent the expenditures subject to the budget neutrality cap (as defined in item 2.c.).

    c) For purposes of this section, the term "expenditures subject to the budget neutrality

cap" shall include all expenditures on behalf of the individuals included in the Demonstration Populations (as described in item 3 of this section), as well as Demonstration Expansion Services (as described in item 4 of this section). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9Waiver and/or 64.9P Waiver.

d) Premiums and other applicable cost sharing contributions from enrollees collected by the State from enrollees in Demonstration Populations 1 and 2 shall be reported to CMS on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, the IowaCare premium collection should be separated from other collections in the Iowa Medicaid program and reported in the memo portion of the CMS report as well as reported on line 9.D of the CMS-64 Summary Sheet.

e) Administrative costs shall not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

27. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the following three categories of enrollees:

a) **Expansion Population.** (Demonstration Population 1)
   (i) I ndividuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under Title XIX; and
   (ii) Parents whose incomes between 0 and 200 percent of the FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, and who are not otherwise Medicaid eligible.

b) **Spend-down Pregnant Women.** (Demonstration Population 2) Newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses of all family members that reduce available family income to 200 percent of the FPL.

c) **Seriously Emotionally Disabled Children.** (Demonstration Population 3) Children from birth to age 18 who have serious emotional disabilities and who:
   - Would be eligible for State Plan services if they were in a medical institution; and
   - Who need home and community-based services in order to remain in the community;

   And who:
   - Have income at or below 300 percent of the SSI Federal benefit; or
   - Have net family income at or below 250 percent of the FPL for family size.

28. For the purposes of this Demonstration, the term "Demonstration expansion services" refers to:

   a) **Demonstration Expanded Services 1**: Expenditures for services not otherwise covered under the Medicaid State plan provided to individuals in eligibility groups receiving only limited benefits under the Medicaid State plan.
   b) **Demonstration Expanded Services 2**: Expenditures for care and services furnished by or through the Department of Human Services under the Mental Health Transformation Pilot that would not otherwise be covered under Title XIX or this Demonstration.

29. The standard Medicaid funding process shall be used during the Demonstration. Iowa must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

30. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Attachment B:

   a) Administrative costs, including those associated with the administration of the Demonstration;
   b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
   c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.

31. The State shall certify State/local monies used as matching funds for the Demonstration

and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

32. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

VIII. MONITORING BUDGET NEUTRALITY

33. Iowa shall be subject to a cap on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

34. Budget neutrality is determined on an aggregate cap basis as follows:

a) For each year of the budget neutrality agreement an annual cap is calculated for the entire Demonstration.
b) The annual limit for the base year (FFY 2006) is $102.2 million.
c) Years 2 -5 of the demonstration period have an annual cap determined by applying a trend rate of 7% to the previous year's cap.
d) The budget neutrality cap for the Demonstration is the sum of the annual caps for the demonstration period:

Demonstration Year	Annual Budget Neutrality Cap
FFY 2006	$102.2 million
FFY 2007	$109.4 million
FFY 2008	$117.0 million
FFY 2009	$125.2 million
FFY 2010	$134.0 million
Cumulative Total	**$587.7 million**

e) Notwithstanding item d above, the budget neutrality cap for the Demonstration may be increased to accommodate caseload growth for Demonstration Population 3. Should caseload exceeds 300 person-year participants in Demonstration Population 3 during any year of the Demonstration, the annual budget neutrality cap for that year will be increased to make an allowance for caseload growth if the cost of the Demonstration appears to be exceeding budget targets. Retrospective adjustment will be considered for up to seven years after implementation of the Demonstration (up to

two years following the five year demonstration project period).

i) The increase in the annual budget neutrality cap shall be calculated as a product of the number of children enrolled in Demonstration Population 3 which exceeds 300, times the per member per year (PMPY) cost of providing services to Demonstration Population 3.

ii) The PMPY costs are determined by applying trend rate of 7.0 percent to the SFY 2006 cost of services provided to Demonstration Population 3 (estimated to be $30,658.04 per year for SFY 2006 in Iowa's HCBS application).

35. The Federal share of this limit shall represent the maximum amount of FFP that the State may receive during the approved demonstration period for the IowaCare program. For each DY, the Federal share shall be calculated using the Federal medical assistance percentage (FMAP) rate(s) applicable to that year.

36. Expenditures for Demonstration Expanded Services 2 shall be capped at the following amounts for each year of the Demonstration:

DY	Annual Limit on Expenditures for Demonstration Expanded Services 2
FFY 2006	$26 million
FFY 2007	$26 million
FFY 2008	$26 million
FFY 2009	$9 million
FFY 2010	$0

37. The expenditure limits outlined in item 4 above will not apply to Demonstration Expanded Services 2 if the Mental Health Transformation Pilot is successful in moving these services from institutional settings to non-institutional settings and/or under the management of a Prepaid Inpatient Health Plan. This determination shall be made each year, based on the IowaCare implementation plan updates required by Section X.
    a) In FFY 2009, the $17 million reduction in the expenditure limit may only be expended for non-institutional services or PIHP payments.
    b) In FFY 2010, the $26 million reduction in expenditure limits may only be expended for non-institutional services or PIHP payments.

38. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the Demonstration years, the State shall submit a corrective action plan to CMS for approval.

Year	Cumulative Target (Total Computable Funds)	Cumulative Target Definition	Percentage
1	$103.2 million	Year 1 budget neutrality cap plus	1 percent
2	$212.6 million	Years 1 and 2 combined budget neutrality caps plus	0.5 percent
3	$328.6 million	Years 1 through 3 combined budget neutrality caps plus	0 percent
4	$453.8 million	Years 1 through 4 combined budget neutrality caps plus	0 percent
5	$587.7 million	Years 1 through 5 combined budget neutrality caps plus	0 percent

The State shall subsequently implement the approved corrective action plan.

39. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the State assures CMS that the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

40. After December 31, 2005, no duplication of coverage of the Part D benefits shall be provided under this Demonstration.

IX. MEDICAID REIMBURSEMENT AND FINANCE

41. The State will not finance the non-federal share through the imposition of any new health care provider taxes during the period of the demonstration including, without limitation, taxes on hospitals, nursing facilities, physicians or pharmacies. (Note: changes in federal law related to health care related taxes will be applicable to the existing Iowa ICF/MR tax.)

    a) By July 1, 2005, the State shall formally withdraw pending State Plan Amendment (SPA) 03-24, submitted to CMS on December 12, 2003 with a proposed effective date of October 1, 2003. This SPA proposed to increase reimbursement to nursing facilities (NFs) based on collection of a proposed variable rate NF service tax.

42. The State shall submit or, if applicable, resubmit formal SPAs in accordance with Section 1915 (f) of the Social Security Act as interpreted by 42 CFR 430.10 as follows:

    a) The State shall resubmit responses to CMS request for additional information related to pending SPAs 03-012, 03-023, and 04-013 with revised state plan language terminating inpatient UPL supplemental payments, supplemental disproportionate share payments, supplemental graduate medical education payments, and nursing facility UPL supplemental payments in which providers qualifying for said payments do not retain the total computable amount claimed by the state. The payment methodologies authorizing each of the above referenced payments must be terminated

by June 30, 2005.

i) SPA 03-012 modifies several factors used in setting regular inpatient hospital payment rates, which in turn would affect existing supplemental inpatient payments that are returned to the State by state and non-state government hospitals.
ii) SPA 03-023 modifies several factors used in setting regular nursing facility payment rates, which in turn would affect existing supplemental NF payments that are returned to the State by non-state government nursing facilities,
iii) SPA 04-013 modifies several factors used in setting regular nursing facility payment rates, which in turn would affect existing supplemental NF payments that are returned to the State by non-state government nursing facilities.

b) The State shall submit new SPAs effective July 1, 2005 limiting total Medicaid payments for inpatient hospital services, outpatient hospital services and nursing facility services, including graduate medical education payments, and any other supplemental payments, to each Iowa government-operated hospital and each Iowa government-operated nursing facility to no more than the actual medical education and medical assistance costs of each such facility as reported on the Medicare 2552 hospital and health care complex cost report (CMS Form-2552) submitted to the CMS and shall be funded consistent with federal statute and regulations. Disproportionate share hospital payments will be limited to the State's DSH allotment and applicable hospital-specific DSH limits and shall be funded consistent with federal statute and regulations.

43. Further, the State shall resubmit SPA 04-007 limiting payment for the high cost adjustment payments for state owned hospitals with over 500 beds to the time period of July 1, 2004 through June 30, 2005. This SPA provides in part for a payment to be added on to the blended base amount for Iowa state-owned hospitals with over 500 beds to adjust for the high cost incurred for providing services to Medicaid patients. The State must provide assurances that the non-federal share of any high-cost adjustment payment is provided according to the relevant statutory and regulatory provisions and that providers retain 100% of the total claimed expenditure.

44. The State shall submit a revised version of SPA 03-017, which proposed new supplemental payments for physician services at publicly owned acute care teaching hospitals. The SPA proposed to pay qualifying physicians the difference between the base Medicaid rate and the provider's usual and customary charges. The revised version of SPA 03-017 will provide supplemental payments to qualifying physicians based upon the Medicare fee schedule or the average commercial rate. SPA 03-017 will be effective for the time period of July 1, 2003 through June 30, 2005.

The State must provide assurances that the non-federal share of any supplemental physician services payments is provided according to the relevant statutory and regulatory provisions and that providers retain 100% of the total claimed expenditure.

45. As described in SPA's 04-007 and 03-017, the total Medicaid payments resulting from the Medicaid services provided to Medicaid enrollees are approximately $59.7M. The Iowa State legislature will appropriate to the Iowa Medicaid agency an amount equal to the non-Federal share of the Medicaid payments made under SPA's 04-007 and 03-017 respectively. The total computable Medicaid payments related to these supplemental payments for the period that they are in effect shall not exceed $54,639,129.

46. This demonstration proposes to provide monthly prospective interim payments to hospitals in the provider network serving Demonstration Populations 1 and 2, as well as to the providers rendering Demonstration Expansion Services 2. The State shall submit a new SPA effective July 1, 2005 fully describing this new payment methodology.

47. The University of Iowa Hospitals and Clinics (UIHC) was appropriated "State Papers" funding of $27,284,584 for fiscal year 2005 and $27,354,545 for fiscal year 2004, for a total of $54,639,129. The funding was originally provided to the UIHC to pay for medical services to indigent persons served at the UIHC, who are not eligible for Medicaid coverage. The Iowa State Legislature will reauthorize these appropriations and will appropriate additional funds to both the Iowa State Medicaid agency as described above and the Health Care Transformation Account.

48. All future State Plan Amendments that will affect any of the Demonstration Populations must be submitted to CMS 30 days prior to execution. Any Amendment submitted after this date shall subject the State to deferred federal financial participation for Demonstration Population and service expenditures.

49. The State must submit by September 30, 2005 a revised *inpatient* hospital upper payment limit methodology, which is based on the acuity of services provided to Medicaid beneficiaries, effective for services beginning July 1, 2005.

X. OPERATIONAL ISSUES

50. Pursuant to Section II, paragraph 6, changes related to eligibility, enrollment, enrollee rights, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, Federal financial participation, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration, following the process set forth in Section II, paragraph 7. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list that shall contain all elements of the Demonstration that are subject to the amendment process within 60 days of the approval of the Demonstration.

51. Within 60 days of the approval of the Demonstration, the State shall develop a detailed "Implementation Plan" that will provide specific, measurable goals and the milestones, time lines, cost estimates, and responsible parties for the achievement of the goals outlined in HF 841. Recognizing that this Demonstration is only one component of a larger Medicaid transformation project, the State shall provide plans and regular updates

on all facets of the transformation project, including timeframes and benchmarks.

52. Upon approval by CMS, the Implementation Plan shall serve as the guiding document for the programmatic aspects of the Medicaid transformation project, including this Demonstration, for the duration of the Demonstration. The Implementation Plan shall address:

    a) Activities undertaken to implement community based services to meet the needs of individuals in the Mental Health Transformation Pilot. This will result in moving the State toward Federal match funding of a managed care program for the mentally ill with an emphasis on deinstitutionalization. The Federal expenditure matching limits in Section VIII, paragraph 40 may not apply based on annual updates to this section of the Plan.
    b) Plans for implementing continuum of care mechanisms for this Demonstration including marketing, enrollee education, and provider education.
    c) Description of the State's quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be employed to monitor service delivery under the Demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.
    d) Implementation of the personal health improvement plans for the Expansion Population.
    e) Quality monitoring activities for services rendered to Seriously Emotionally Disabled Children.
    f) Access to care for the Expansion Population, including possible provider network expansions, including free clinics, Federally Qualified Health Centers, Rural Health Clinics, and small professional practices in areas with limited access to healthcare professionals.
    g) Operations of the Account for Health Care Transformation and the IowaCare account.
    h) Actions taken by the State to implement its State Vision Statement for Long-Term Care" including establishing a universal assessment program for long-term care services.
    i) Plans and timeframes for developing and implementing a case mix adjusted reimbursement system for both institutional based and community based services for persons with mental retardation or developmental disabilities.
    j) Plans and timeframes for expanding alternatives for community-based care for individuals who would otherwise require care in an intermediate care facility for persons with mental retardation.
    k) Plans and timeframes for the design and successful implementation of a dietary counseling program by July 1, 2006.
    l) Identification of Quality Control mechanisms, indicators and reports for each phase of implementation including how variations from expected norms are incorporated into plans for improvement.

53. The following performance benchmarks shall be reflected in the Implementation Plan:

   a) By October 1, 2006, the State shall develop a practical strategy for expanding utilization of electronic medical recordkeeping by providers under the medical assistance program and the expansion population provider network.
   b) By January 1, 2007, the State shall design and implement a provider incentive payment program for providers under the medical assistance program and providers included in the expansion population provider network based upon evaluation of public and private sector models
   c) By July 1, 2007, the State shall implement a program with the goal of reducing smoking among recipients of medical assistance who are children to less than one percent and among recipients of medical assistance and expansion population members those who are adults to less than ten percent,
   d) By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program
   e) Provide to CMS by March 1, 2006 a copy of the Indigent Care Task Force's preliminary report of its efforts and findings.
   f) Provide to CMS by December 31 each year a copy of the Indigent Care Task Force's annual report.
   g) By July 1, 2006, the State shall submit to CMS a report of the results of an evaluation of the performance of each component of the Iowa Medicaid enterprise using the performance standards contained in the contracts with the Iowa Medicaid enterprise partners.
   h) Report at least annually to CMS on the activities of the Medical Assistance Projections and Assessment Council.
   i) Report at least annually to CMS the results of the study conducted by the State on barriers to private insurance for Iowans and possible impacts on this Demonstration project.

54. Substantial changes to the Implementation Plan shall be submitted to CMS for approval at least thirty days prior to the implementation of the change.

XI. EVALUATION

55. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify

whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

56. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of the Demonstration.

57. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.