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Dear Mr. Concannon;

We are pleased to inform you that your IowaCare Medicaid demonstration application, Project No. XX, has been approved for 5 years effective July 1, 2005, to June 30, 2010 (the project period). Approval of this project is granted under the authority of section 1115 of the Social Security Act (the Act). The 1115 Family Planning waiver and 1915c Children's Mental Health waiver have also been approved for the 5 years but in separate approval letters, with separate terms and conditions for these waivers and have been submitted under separate cover.

The IowaCare project is a unique partnership between the Centers for Medicare and Medicaid Services (CMS) and the State of Iowa. Its purpose is to effect measurable improvement in the health care available to, and the health status of, Iowans who are currently unable to access affordable quality care. It will do so by providing a limited Medicaid benefit to as many adults ages 19 through 64 with income at or below 200% of the federal poverty level as possible and by strengthening Iowa Medicaid's capacity and authority to manage health care utilization, quality and costs in partnership with its members and providers, with private health insurers and employers, as well as with other Iowa state agencies and with CMS.

We believe that the lessons learned during the course of this project will be useful to the State of Iowa, to CMS and to other states interested in achieving similar goals. Consequently, thorough, timely and regular project reporting in formats and media readily accessible to CMS, to other states and to the general public are critical elements of this project.

After careful consideration the Iowa legislature passed and Governor Thomas J. Vilsack signed HF 841 to authorize the IowaCare project. HF 841 provides detailed guidance to the Iowa Department of Human Services (DHS, the single state Medicaid agency) regarding all matters referred to in this letter and in the enclosed Special Terms and Conditions (STCs). Our approval of this project is contingent upon the State's compliance with HF 841 and the STCs. Approval of this project is also subject to our receiving your written acceptance of the STCs within 10 calendar days of the date of this letter.

It is very important to emphasize that approval (and continuing approval) of the IowaCare project is contingent on State action, in all of the following areas either throughout, or for some period of time during, the life of the project.

Beginning, July 1, 2005, Iowa shall provide a limited health benefit package, including limited hospital and physician care, to as many individuals as possible with family incomes at or below 200% of the FPL, and to a limited group of pregnant women who spend down to 200% because of medical costs. (together “the demonstration population”).

Iowa shall demonstrably expand employer-based health coverage for the demonstration population through Medicaid supported employer and/or employee payment assistance programming.

Iowa shall demonstrably expand access to quality home and community based health care choices for the frail elderly, physically disabled and mentally ill, and those with developmental disabilities and mental retardation.

Iowa shall demonstrably improve the health status of individuals enrolled in Iowa Medicaid.

Iowa shall demonstrably expand the role of Iowa Medicaid members in improving their own health preventing and, treating disease, avoiding unnecessary care costs, and in sharing, to the extent fair and practical, in the cost of the care of themselves and their family.

Iowa shall demonstrate the potential of a Medicaid enterprise approach, linked to the CMS Medicaid Information Technology Architecture (MITA) initiative, to provide quality care to a medically diverse population at a cost at least comparable to the cost of the same care for the same population if purchased from private managed care organizations and/or private insurers.

Iowa shall demonstrate, to the extent possible, steps to “normalize” the impact of Medicaid in the Iowa health care market (i.e., avoid cost-shifting from Medicaid to other payors and insureds) by adopting utilization management, operational performance standards, program integrity, and provider reimbursement policies that are similar to those of like size payors with similar memberships and benefit plans.

Iowa shall demonstrate the potential of new information technologies to improve health care and reduce medical errors, particularly for highly vulnerable Medicaid populations.

Iowa shall assess the impact of the new governing and operational structures mandated in HF 841 and SF 272 on Medicaid program performance. SF 272, increases to 50% the number of current and former Medicaid members, their families and advocates on the Iowa Medicaid Advisory Council. HF 841 provides for official quarterly Medicaid cost estimates by a committee of the legislature.

Some of the activities described above, and more specifically in HF 841, and Iowa's 1115 waiver application, involve assessments of other states' experience (and the private sector) with similar programs, and extensive design and development activities prior to program implementation. For example, Iowa proposes to design and develop an employer-sponsored insurance (ESI) pilot program, a health care account option for the expansion population, a case-mix adjusted reimbursement system for ICF/MR services, mandatory health screenings for the expansion population, a dental home program for children through age 12, a provider performance incentive program, and flexible smoking cessation and dietary counseling programs that may include coverage for certain additional services. In such cases, CMS and Iowa will need to review, and reach mutual agreement on aspects of program implementation. It is Iowa's responsibility to ensure that prior to installing any such program changes, it has secured all of the additional authority required from CMS to implement such changes, either for the expansion population or for the regular (optional and mandatory) Iowa Medicaid population.

Approval of the Iowa project also requires that Iowa, during the 5-year term of the project:

Not impose any new health care provider taxes ("Iowa prohibited health care provider taxes") including, without limitation, hospital, nursing facility, physician or pharmacy, provider taxes. (Note: any future adjustments to the rules regarding taxation of ICF/MRs will be applicable to the existing Iowa tax.)

Limit payments for services, including graduate medical education payments, to each Iowa public hospital and each Iowa public nursing facility to no more than the actual medical education and medical assistance costs of each such facility as reported on the Medicare hospital and health care complex cost report submitted to the CMS ("Iowa public hospital and public nursing facility upper payment limit").

Note: Hospital Disproportionate Share (DSH) payments are not subject to this limitation, but nothing in this project approval is intended to increase Iowa's annual DSH allotment beyond that provided under current law. This approval does, however, modify the application of current limitations on DSH payments to institutes for mental disease.

Allow each public hospital and each public nursing facility to retain one hundred percent of the medical assistance payments earned under state reimbursement rules. (State reimbursement rules may provide for reimbursement at less than actual cost.) i.e., there shall be no "recycling" of federal funds.

Contract with an independent certified public accountant to provide an annual evaluation, to the Governor, the General Assembly and CMS, regarding Iowa medical assistance program compliance with each of the following:

1. That the state has not instituted any new provider taxes as defined by the CMS.
2. That public hospitals and public nursing facilities are not paid more than the actual costs of care for medical care and medical education based upon Medicare program principles of accounting and cost reporting.
3. That the state is not “recycling” federal funds provided under Title XIX of the Social Security Act as defined by the centers for Medicare and Medicaid services of the United States department of health and human services.

Contract with the Iowa Division of Insurance or other appropriate entity to track, on an annual basis, the number of uninsured and underinsured Iowans, the cost of private market insurance coverage, and other barriers to access to private Insurance for Iowans. Results are to be reported to CMS annually.

All of the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter apply to the demonstration.

Under the authority of section 1115 (a)(1) of the Act, the following waivers are approved for a 5-year period beginning with the implementation date of the demonstration:

1. Eligibility Section 1902(a)(10)

To enable the State to limit, close or reduce the expansion population if the State determines that federal or state funds will not be available to pay for existing or additional enrollment.

2. Amount, Duration and Scope of Services Section 1902(a)(10)  
Section 1902(a)(10)(B)

To enable the State to provide a limited benefit package to individuals ages 19 through 64 who a) are not eligible for Medicaid due to being over income, over resources or not meeting categorical eligibility; b) have income is at or below two hundred percent of the federal poverty level; c) individuals with income below three hundred percent of the federal poverty level and spend down to two hundred percent of the federal poverty level may also be eligible for obstetrical and newborn care. Individuals eligible for the family planning benefits authorized under the medical assistance family planning services waiver, may also be eligible for expansion population benefits.

To allow services for the expansion population that will in type scope and duration that are less than the medical services available to mandatory and optional populations under Title XIX.

3. Eligibility Procedures Section 1902(a)(10)(A)  
Section 1902(a)(34)

To enable the State to apply streamlined income eligibility rules for individuals and a different definition of income for eligibility purposes. The 3-month retroactive coverage will not apply and income eligibility will be based only on **gross** income.

4. Premiums Section 1902(a)(14)

To enable the state to assess each individual in the expansion population a monthly premium not to exceed the following: a) Each expansion population member whose family income equals or exceeds one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human Services will pay a monthly premium not to exceed one-twelfth of five percent of the member's annual family income and, b) each expansion population member who's family income is less than one hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human Services will pay a monthly premium not to exceed one-twelfth of two percent of the member's annual family income and; c) the Department will waive the required out of pocket expenditures for an individual expansion population member based on a hardship that would accrue from imposing such required expenditures. The premium may be adjusted based on the individual's increased wellness activities, such as smoking cessation or compliance with a personal health improvement plan.

5. Comparability of Eligibility Section 1902(a)(17)

To enable the State, for the demonstration population only, to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income).

6. Freedom of Choice Section 1902(a)(23)

To enable Iowa to limit the expansion population provider network to certain Iowa safety net providers. Provider access (but not program eligibility) may be limited for the demonstration population on the basis of county of residence.

7. Early Periodic Screening, Diagnosis And Treatment (EPSDT) Section 1902(a)(43)(A)

To enable Iowa to provide limited benefits to the expansion population ages 19 through 21 without regard to the Early and Periodic Screening, Diagnosis, and Treatment Program requirements.

Under the authority of section 1115(a)(2) of the Social Security Act, the following expenditures that would not otherwise be regarded as expenditures under section 1903 will, for the 5-year period. July 1, 2005 be regarded as expenditures under the State's Title XIX plan:

1. Expenditures in the form of prospective interim monthly payments to hospitals in the expansion population provider network.
2. Medical expenditures for pregnant women with income at or below 300% FPL who spend down to 200% solely on account of pregnancy related medical expenses.
3. Medical expenditures for adults age 19 through 64 with family incomes at or below 200% of the FPL.
4. Expenditures for inpatient and outpatient hospital services and other services provided to the regular Medicaid population and to the expansion population at the four state mental health institutes.
5. Expenditures for hospital disproportionate (DSH) share payments to the four state mental health institutes to the extent such payments (collectively) do not exceed 25% of the state's DSH allocation for the year.

The following State Plan Amendments (SPA) are approved in connection with and/or to make possible, the implementation of the IowaCare project.

1. SPA's 01-040 and 01-041 to eliminate the mechanism to secure funds based on hospital inpatient and outpatient prospective payment (upper payment limit) methodologies effective June 30, 2005.
2. Amendments to SPA's 92-038 and 93-011 to eliminate the mechanisms to receive supplemental disproportionate share hospital and indirect medical education funds to be effective June 30, 2005.
3. SPA 99-037 to eliminate the mechanism to secure funds based on the skilled nursing facility prospective payment (upper payment limit) methodologies effective July 1, 2005.
4. SPA 03-012, which consists of inpatient hospital reimbursement technical changes.
5. SPA 03-023, which revises two nursing facility accountability measures.
6. SPA 04-013, which adjusts the allowable cost calculations for the most recently published HCFA/SNF index and reduces the excess payment allowance calculations.

The following State Plan amendments are approved for limited periods of time on condition that all of the Federal funds received by the State of Iowa on account of the approval of the SPAs be deposited in the Account for Health Care Transformation created by Section 24 of HF 841. Funds in this Account may only be used for the purposes specified in Section 24 of HF 841. They will be matched at the applicable Federal Financial Participation Rate only if used for such purposes and only if otherwise allowable under Title XIX. An accounting of all expenditures from the fund shall be provided to CMS annually.

1. SPA 04-007, which provides 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 payments for the fiscal year beginning July 1, 2004, and eliminate effective June 30, 2005.
2. SPA 03-017 for supplemental payments to physicians at publicly owned acute care teaching hospitals beginning July 1, 2003 and eliminate effective June 30, 2005.

In its initial request for approval of the IowaCare project concept, Iowa emphasized that without approval of IowaCare, the State would be forced to amend its state plan to limit eligibility for optional populations and/or limit or eliminate optional services. While Iowa will, of course, retain the authority to so amend its state plan during the 5-year project period, CMS expressly reserves the right to re-evaluate its approval of the entire IowaCare project, if Iowa adopts such amendments to its Title XIX or Title XXI state plans.

In its request for approval of the IowaCare project, Iowa has also emphasized that it shares President Bush's strong interest in 'rebalancing' the long term care system to emphasize cost-effective, quality home and community based care options for children and adults. Iowa is developing a measured and informed approach to this task. The IowaCare project contains some important elements of this strategy:

Instead of simply increasing the medical level of care requirements for nursing facility admission, it is requested and we approve the following:

That medical eligibility standards for home and community waiver services in effect in Iowa on April 1, 2005 will remain in effect throughout the 5 year project period. However, pursuant to HF 841, the medical eligibility standards for nursing facility services, will be raised for persons who have not been resident in a nursing facility prior to July 1, 2005 and for whom medically appropriate waiver services are, in fact, available in their community. Those individuals who meet the waiver service standard, but cannot meet the higher nursing facility standard, will be required to utilize the waiver services in lieu of nursing facility services if those waiver services are, in fact, available to them in their community. Nothing in this approval shall preclude licensed nursing facilities from becoming waiver

service providers, so long as such activity is consistent with pertinent Iowa and Federal rules and regulations.

Iowa will design and implement a case-mix adjustment rate system for its large (relative to other states) ICF/MR population, with a view to strengthening the entire continuum of care available to this population.

Provide alternative access to services for families whose children have mental health, behavioral or emotional disorders and who heretofore felt it necessary to relinquish custody of their children, in order to access services for their child's mental health needs.

Iowa has also assured us that:

In June 2005, Iowa will submit waiver amendments to the CMS for Iowa's six Home and Community Based Service (HCBS) waivers for a self directed service option called *Developing Choices-Empowering Iowans*. Recipients who elect to participate will be provided a monthly allowance that equals the amount that would be approved under their traditional HCBS for the care authorized. Recipients may choose to hire relatives (excluding spouses), neighbors, or friends as caregivers.

Iowa will amend its Elderly Home and Community Based Services (HCBS) waiver to provide for inclusion of case management services.

In view of this, as a condition of this waiver CMS requires that Iowa develop, during the project period, a CMS approved method for reporting over time the State's success in changing the types of long term care services utilized to meet the case mix adjusted care needs of the Medicaid population. This report must address the frail elderly, the physically disabled, the mentally ill, and individuals with MR and/or DD.

In its request for approval of the IowaCare project concept, Iowa also emphasized that without the approval provided here for SPA 04-007 and for SPA 03-017 the State would be unable to carry out the "health promotion partnerships" identified in HF 841 and expected to be funded from the Account for Health Care Transformation created by section 24 of HF 841. Since CMS approval of the IowaCare project is premised upon a good faith effort on the part of the State to implement each of those "health promotion partnerships" detailed in HF 841, CMS reserves its right to re-evaluate its approval of the IowaCare project if the State fails to demonstrate a good faith effort to do so.

In its request for approval of the IowaCare project, the State also emphasized that its capacity to manage Iowa Medicaid effectively and efficiently in the coming years will be significantly enhanced by its adoption of an "enterprise" approach, consistent with the MITA concept, which is a major CMS initiative. Our approval of the IowaCare project relies in part on our expectation that the state will utilize this "enterprise concept" and pursuant to section 17 of HF 841 will arrange for an independent assessment of the cost and quality of care that can be delivered using this concept. CMS, therefore reserves the

right to re-evaluate the IowaCare waiver, if it appears from these reports that the cost and quality of the Iowa Medicaid program could be substantially improved through available capitated managed care or other insurance. For purposes of comparison the Iowa Medicaid program should be compared to the costs of managed care and private insurance covering the same population and providing the same covered services (type, scope and duration).

There are several things about CMS' approval of the IowaCare project which must be emphasized both for Iowa and for other states who may seek to implement similar demonstrations:

First, the "whole" project is more valuable to CMS as a demonstration project than any of its component parts.

Second, the State's readiness and capacity to implement a Medicaid project of this scope, as demonstrated by the strong bi-partisan efforts, and leadership involvement that went into the preparation and swift enactment of HF 841, including specific appropriations for each element of IowaCare for SFY 2006, weighed heavily in CMS' decision to approve this project.

Third, CMS considers IowaCare to be a "performance based" waiver. By that it means that the State has been given significant authority to shape a medical benefits program for a new population, while, at the same time, being measured against high performance standards for the entire Medicaid population (demonstration, mandatory and optional).

For these reasons, CMS has agreed in this waiver to approve some things, which would not have been approved on a "stand-alone" basis. For example, Medicaid coverage for services provided by an institute for mental disease, broad authority to vary the scope and duration of medical benefits and to define the demonstration population, and allowing the state to limit access to service providers for the demonstration population only. CMS has agreed to approve these because, from Iowa's perspective, they are a critical part of its overall strategy – and from CMS' perspective Iowa's overall strategy – if successfully implemented -- can provide very valuable lessons for CMS and for other states as they look to shape a new national strategy for Medicaid in the coming weeks, months and years.

Your Project Officer for the Title XIX demonstration is \_\_\_\_\_ Ms. \_\_\_\_\_  
contact information is as follows:

Center for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
7500 Security Boulevard, Mail Stop S  
Baltimore, Maryland 21244-1850

Telephone:  
Facsimile  
E-Mail

Official communications regarding program matters should be sent simultaneously to \_\_\_\_\_, the Associate Regional Administrator in our Kansas City Regional Office. Mr. \_\_\_\_\_ address is:

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

We extend our congratulations on this award and look forward to working with you on this innovative project.

Sincerely,

Mark McClellan  
Administrator

Enclosures

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## SPECIAL TERMS AND CONDITIONS

### I. PREFACE

The following are Special Terms and Conditions for the Iowa Section 1115 demonstration. The Special Terms and Conditions have been arranged into the following subject areas: General Program Conditions, General Reporting Requirements and Legislation. All terms and conditions in the Secretary's approval letter dated June 15, 2005 are hereby-incorporate herein by reference.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

The State agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

### II. GENERAL PROGRAM CONDITIONS

**1. Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing limits; and reporting on financial and other issues.

**2. Public Notice and Consultation.** The State will continue to comply, as demonstrated by previous documentation, with the public notice requirements published in the September 27, 1994 edition of the Federal Register, and the tribal consultation requirements issued via letter by CMS on July 17, 2001. In the event the state conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

**3. Extension or Phase-out Plan.** No later than 12 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than one year prior to the expiration of the demonstration. If the state does not intend to request an extension, it must submit to CMS a phase-out plan no later than one year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

**4. Enrollment Limitation During the Last Six Months.** If the demonstration has not been extended, no new enrollment is permitted during the last six months of the demonstration.

**5. 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 program.

**6. CMS Right to Terminate or Suspend.** The CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, whenever it determines that the state has materially failed to comply with the terms of the project. The CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the state materially failed to comply. CMS reserves the right to deny pending waiver requests or costs not otherwise matchable, or withdraw waivers or costs not otherwise matchable, at any time, if it determines that granting or continuing the waivers or costs not otherwise matchable would no longer be in the public interest. If the project is terminated or any relevant waivers or costs not otherwise matchable withdrawn, CMS will be liable for only normal closeout costs.

**7. State Right to Terminate or Suspend.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant waivers suspended by the state, CMS will be liable for only normal close-out costs.

### **III. GENERAL REPORTING REQUIREMENTS**

**1. Quarterly Progress Reports.** Iowa will submit quarterly progress reports, which are due 60 days after the end of each quarter. The format for the report will be agreed upon by CMS and the state. These reports must include information on operational and policy issues appropriate to the State's program design. It must also include information on any issues that arise in conjunction with the premium assistance portion of the program.

**2. Quarterly Enrollment Reports.** Each quarter the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and ever enrolled figures.

**3. Monitoring Calls.** CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration.

**4. Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status, financial updates, quantitative and case study findings, policy and administrative difficulties including results of data collection and analysis of data, no later than six months after the end of its operational year. Within 30 days of receipt of comments from CMS, the State shall submit a final annual report.

**5. Final Report.** No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS's comments shall be taken into consideration by the state for incorporation into the final report. CMS's document Author's Guidelines: Grants and Contracts Final Reports is available to the state upon request. The final report is due no later than 90 days after the receipt of CMS's comments.

#### **IV. LEGISLATION**

**1. Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are a part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

**2. Changes in Medicaid Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program elements of the Demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology for complying with the change in law to CMS for approval. The methodology must be consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

**3. Amending the Demonstration.** The State may submit to CMS a request for an amendment to the Demonstration program to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified

Demonstration program do not exceed projected expenditures in the absence of the Demonstration (assuming full compliance with the change in law).

## ATTACHMENT A

### GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. The State will 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. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration). Federal financial payment will not be provided for expenditures financed by collections in the form of pharmacy rebates, enrollment fees, or third party liability.

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will 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 or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

b. See Attachment B for a description of "expenditures subject to the budget neutrality cap".

c. For each demonstration year a Form CMS-64.9WAIV and/or 64.9PWAIV will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

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

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VIII).

3. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

4. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate 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. Medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

5. The State will certify State/local monies used as matching funds for the IowaCare project and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.



Family planning expenditures, during the waiver period, for individuals who are enrolled in any approved Section 1115 family planning waiver will be considered as medical expenditures for purposes of the IowaCare demonstration, but will be subject to the budget neutrality requirements of that waiver.

The federal share of hospital service provider payments to the four Iowa state mental health institutions (MHIs) for (mandatory or optional category) for persons who are or would be eligible for Medicaid under the Iowa State Plan in effect on April 1, 2005 will be counted as medical expenditures under the IowaCare project for budget neutrality purposes. In addition, the federal share of Medicaid Hospital Disproportionate Share and Medical Education payments to the four MHIs will be counted as medical expenditures under the IowaCare project for budget neutrality purposes.

The federal share of all revenues associated with the demonstration population, including, without limitation the federal share of all premium revenue and third party revenue, will be added to the federal budget reimbursement limits set forth above. However, revenues will only be recognized for this purpose when received.

The federal reimbursement limits set forth above shall be reduced by:

- a. 100% of any revenue received by the State from any "Iowa prohibited health care provider taxes" (as defined in the IowaCare approval letter); and
- b. 100% of all federal reimbursement paid for medical services provided by any public hospital or nursing facility where the provider payment exceeds the "Iowa public hospital and public nursing facility upper payment limit" (as defined in the IowaCare approval letter); and
- c. 100% of any "recycled" federal dollars (included in the IowaCare approval letter).

CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the waiver period, or provider related donation that occurred during the waiver period, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.