THE DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

NOV 1 5 2019

Michael Randol
Medicaid Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

Dear Mr. Randol:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Iowa's (the state's) section 1115(f) extension request for its section 1115 demonstration project, entitled, "Iowa Wellness Plan" (Project No. 11-W- 00289/5) (demonstration), in accordance with section 1115 of the Act.

This approval is effective from January 1, 2020, through December 31, 2024. CMS approval is subject to the limitations specified in the attached waivers and special terms and conditions (STC). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or listed as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the project is likely to assist in promoting the objectives of title XIX.

The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of beneficiaries in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of beneficiaries in need, including by expanding the services and populations they cover.[1] By the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

---

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Iowa

Iowa's Medicaid program provides for health coverage to mandatory populations and to non-mandatory populations such as the breast and cervical cancer group. The state also covers several categories of non-mandatory services, including prescription drugs, dental services, and home-and -community-based services, in addition to mandatory services. In addition, effective January 1, 2014, Iowa expanded its Medicaid program to include coverage through the state plan of the new adult group (also known as the ACA expansion population) described at section 1902(a)(10)(A)(i)(VIII) of the Act.

Extent and Scope of the Demonstration

The Iowa Wellness Plan (IWP) demonstration was first implemented on January 1, 2014, at the same time that Iowa's expansion of Medicaid to the new adult group took effect. The Iowa Wellness Plan (IWP) demonstration initially sought to promote responsible health care decisions among the ACA expansion population by coupling a monthly required financial contribution with an incentive to earn an exemption from the monthly contribution requirement by actively seeking preventive health services.

As initially approved, the demonstration also provided authority for a waiver of non-emergency medical transportation (NEMT) for the ACA expansion population. The waiver of NEMT was scheduled to sunset on December 31, 2014, with the possibility of extending based on an evaluation of its impact on access to care. After reviewing initial data on the impact of the waiver on access, CMS approved an extension of the NEMT waiver through July 31, 2015. Thereafter, CMS and the state established criteria necessary for the state to continue the NEMT waiver beyond July 31, 2015. Specifically, the state agreed to compare survey responses of the beneficiaries affected by the waiver to survey responses of beneficiaries receiving "traditional" Medicaid benefits through the state plan. Iowa conducted the analysis and found that the survey responses of the two populations did not have statistically significant differences. In light of

---

include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

those results, CMS approved a second extension of the waiver through June 30, 2016. Based on the state's ongoing analysis and evaluation of the impact of the NEMT waiver on access to covered services, the waiver of NEMT was extended again, and is still part of the demonstration. According to the most current analysis, the Iowa Health and Wellness Plan Evaluation Interim Summative Report, April 2019, beneficiaries reported unmet need for transportation was not statistically different for Medicaid beneficiaries (12 percent) and IWP beneficiaries (11 percent). There was no statistical difference between Medicaid and IWP beneficiaries in reported worry about the cost of transportation with around 8 percent of each group reporting that they worried "a great deal" about their ability to pay for the cost of transportation to or from a health care visit.

On May 1, 2014, CMS approved the state's request to amend the IWP demonstration to include a Dental Wellness Plan (DWP) component, which at that time provided tiered dental benefits, based on beneficiary completion of periodic exams, to the ACA expansion population. All dental benefits covered under the DWP were optional Medicaid services, not mandatory.

Currently, the demonstration still includes an incentive program intended to improve the use of preventive services and encourage health among the ACA expansion population. Under this program, beginning in year two of a beneficiary's enrollment, the state requires monthly premiums for beneficiaries in the ACA expansion population with household incomes above 50 percent up to and including 133 percent of the federal poverty level (FPL). However, beneficiaries with a premium requirement who complete a wellness exam and health risk assessment (HRA) will have their premium waived for the following benefit year. The premium amounts may not exceed $5 per month for non-exempt beneficiaries with household incomes above 50 percent up to and including 100 percent of the FPL, and $10 per month for non-exempt beneficiaries with household incomes above 100 percent up to and including 133 percent of the FPL. Exempt beneficiaries include those who completed the wellness exam and HRA, beneficiaries who are medically frail, beneficiaries of the Health Insurance Premium Payment (HIPP) population, and beneficiaries who self-attest to a financial hardship. IWP premiums are permitted in lieu of other cost sharing except for an $8 copay for non-emergency use of the emergency department. Beneficiaries subject to premiums are allowed a 90-day grace period to make payment. The nonpayment of these premiums will result in a collectible debt. Individuals with household income over 100 percent of the FPL will be disenrolled for nonpayment. Beneficiaries with household income at or below 100 percent of the FPL cannot be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium. Beneficiaries who are disenrolled for nonpayment can reapply at any time; however, their outstanding premium payments will remain subject to recovery. Monthly premiums are subject to a quarterly aggregate cap of 5 percent of household income.

On February 23, 2016, CMS approved the state's request to implement a managed care delivery system for the medical and dental services affected by the IWP demonstration, concurrent with the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

On November 23, 2016, CMS extended the demonstration for three years under section 1115(e) of the Act, through December 31, 2019. This initial extension was approved with no program modifications. Subsequently, the state submitted two amendment requests during the renewal

period. The first amendment, approved by CMS on July 27, 2017, modified the DWP component of the demonstration based on analysis of independent evaluation findings and stakeholder feedback. Through this amendment, the state implemented an integrated dental program for all Medicaid beneficiaries aged 19 and over, including the ACA expansion population, parent and other caretaker relatives, and mandatory aged, blind, and disabled individuals. The tiered benefit structure was removed, and instead, the state established an incentive structure to encourage uptake of preventive dental services. Beneficiaries with household income over 50 percent of the FPL are required to contribute financially toward their dental health care costs through $3 monthly premiums in order to maintain comprehensive dental benefits. Dental premiums are waived in the first year of the beneficiaries' enrollment. Dental premiums will continue to be waived in subsequent years if beneficiaries complete an oral HRA and obtain a preventive dental service in the prior year. Failure to make monthly dental premium payments results in the beneficiary being eligible for only a basic dental services package for the remainder of the benefit year, but beneficiaries will not be disenrolled for failure to pay premiums or the past due amounts. The following eligibility groups are exempt from DWP premiums, and will not have their benefits reduced in their second year of enrollment, notwithstanding any failure to complete state-designated healthy behaviors: (i) pregnant women; (ii) beneficiaries whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs; (iii) 1915(c) waiver beneficiaries; (iv) beneficiaries receiving hospice care; (v) Indians who are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services; (vi) breast and cervical cancer treatment program beneficiaries; and (vii) beneficiaries who are medically frail (referred to as medically exempt in Iowa). Additionally, beneficiaries who self-attest to financial hardship or who are exempt as described in 42 CFR 447.56 will have no dental premium obligation. The program thus creates incentives for beneficiaries to appropriately utilize preventive dental services, maintain oral health, and prevent oral disease. This program is also intended to create incentives for beneficiaries to establish a dental home, because it encourages the receipt of preventive dental services. As was the case before this amendment, all dental benefits covered under the DWP are optional, not mandatory.

On August 2, 2017, Iowa, as directed by its legislature, submitted a request to amend the demonstration to waive retroactive eligibility for all Medicaid beneficiaries. On October 26, 2017, CMS approved the state's amendment request for a waiver of retroactive eligibility for all Medicaid beneficiaries except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy), and infants under one year of age. Under the currently approved demonstration, unless an exemption applies, an applicant's coverage would begin on the first day of the month in which the application is submitted, or as otherwise allowed under the state plan.

Extent and Scope of the Demonstration Extension

On June 20, 2019, Iowa submitted a renewal application under section 1115(f) for a five-year extension, and requested one change to the existing STCs. In accordance with Iowa Senate File 2418 (2018), the state requested to exempt applicants from the waiver of retroactive eligibility who are eligible for both Medicaid and nursing facility services based on level of care, and who

had been a resident of a nursing facility in any of the three months prior to an application. For beneficiaries who are exempted from the waiver of retroactive eligibility due to eligibility for nursing facility services, retroactive eligibility is, and would continue to be, provided for those particular months in which the applicant was a nursing facility resident. The state already applies this exemption, and has done, for applications filed on or after July 1, 2018.

CMS is approving the extension, including the change requested by Iowa to the retroactive eligibility waiver. In extending the approval period, CMS is also updating the waiver of retroactive eligibility to exempt children under 19 years of age. The earliest that a retroactive eligibility period for children under age 19 will begin will be January 1, 2020, for applications filed on or after January 1, 2020. In an abundance of caution, CMS also updated the waiver of retroactive eligibility to include a waiver of section 1902(a)(10) of the Act, to the extent that section 1902(a)(10) imposes a requirement of retroactive eligibility.

CMS has also updated the monitoring and evaluation sections of the STCs to align those sections with CMS' current approach to monitoring and evaluation for section 1115 demonstrations, and to specify that CMS has the authority to require the state to submit a corrective action plan if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid. The STCs further specify that any such state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where data indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, provider uncompensated care costs or unpaid medical bills). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. These updates will better aid the state in measuring and tracking the demonstration's impact on Iowans affected by it, and give CMS additional tools to protect beneficiaries if necessary.

Consistent with sections 1115(f)(6) and 1915(h) of the Act, CMS is approving a five year extension approval period because the demonstration (specifically, the DWP component) provides medical assistance to beneficiaries dually eligible for Medicare and Medicaid.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, CMS has determined that the demonstration as a whole, as extended, promotes the objectives of the Medicaid program, and the waiver authorities sought are necessary and appropriate to carry out the demonstration.

The demonstration tests reforms designed to promote better health outcomes.

Under the extended demonstration, Iowa and CMS will continue to evaluate the effectiveness of various policies that are designed to improve the health of Medicaid beneficiaries, and encourage them to make responsible decisions about their health and accessing health care. Promoting beneficiary health and responsible health care decisions advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects

"aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[2]

The demonstration's premiums and cost-sharing requirements are designed to improve enrollee health and wellness by encouraging the use of preventive services. With this extension, Iowa will be expected to strengthen the evaluation of whether the opportunity for beneficiaries to pay no premium by completing a wellness exam, HRA, and/or oral HRA and preventive dental services, increases beneficiary engagement in their personal health care plan and provides an incentive structure to support responsible consumer decision-making about accessing care and services. A recent interim evaluation of the demonstration has shown some promise that these strategies can have a positive impact on beneficiary behavior. According to the Iowa Health and Wellness Plan Evaluation Interim Summative Report from April 2019, "The vast majority of IWP beneficiaries, regardless of Managed Care Organization (MCO) enrollment (94 -96 percent), reported either having already obtained a medical or dental check-up or intent to get one." Extending this policy is expected to continue to improve beneficiaries' engagement in their health care choices by increasing their awareness of behaviors that might be detrimental to their health, while also encouraging them to make healthier choices. With this extension, CMS has also incorporated specific requirements for evaluating the incentives and premiums, including beneficiary understanding of and experience with premiums as an incentive, the interface between incentives to seek out preventive care and premiums, and consequences of these demonstration policies, including non-compliance with premiums and incentives, on coverage.

The demonstration also promotes responsible decision-making and improved health by encouraging appropriate use of health care services and behavior that is mindful of health care value. Extending this demonstration will allow the state, consistent with 42 CFR 447.54(b), to continue its policy of charging beneficiaries in the ACA expansion population an $8 copayment for utilization of the Emergency Department (ED) for non-emergency services. Iowa believes this policy will help beneficiaries learn about the importance of choosing appropriate care in the appropriate setting—which is generally not the ED—by educating beneficiaries about the direct cost of health care services and the importance of seeking preventive services and similar care in the most appropriate setting. Receiving preventive and similar care in non-emergency settings can improve the health of beneficiaries, because they can build and maintain relationships with their regular treating providers. Over time, this may lead to the prevention and/or controlled maintenance of chronic disease, as prevention and health promotion are difficult to achieve and sustain through episodic ED visits. Additionally, this policy will improve the ability of beneficiaries who truly need emergency care to access it, by preserving ED and state fiscal resources for those who are truly in need of timely emergency care. A recent evaluation of this demonstration has shown some promise that this incentive strategy can have a positive impact on beneficiary behavior. According to the Iowa Health and Wellness Plan Evaluation Interim Summative Report from April 2019, significantly fewer IWP beneficiaries (38 percent) compared to other Medicaid beneficiaries (59 percent) reported that the care at their last visit to the ED could have been provided in a doctor's office.

---

[2] CMS, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid at 15 (Dec. 10, 2012).

The waiver of retroactive eligibility is also expected to help promote Medicaid's objectives by improving uptake of preventive services, thus improving beneficiary health. Iowa is testing whether waiving retroactive eligibility for certain groups of Medicaid beneficiaries will encourage them to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (e.g., if eligibility depends on a certain diagnosis, or on a finding of disability). In circumstances where Medicaid eligibility depends upon a certain diagnosis or a finding of disability, the state will evaluate, in this extension period, whether the policy encourages beneficiaries to apply for Medicaid (including through an application for Supplemental Security Income (SSI) in the case that an SSI determination also provides a Medicaid eligibility determination) as soon as possible after the relevant finding or diagnosis. If beneficiaries apply for Medicaid as soon as they believe they meet the criteria for eligibility, this could help to ensure primary or secondary coverage through Medicaid to receive services if the need arises and facilitate the receipt of preventive care. The state will evaluate whether the policy increases continuity of coverage by discouraging gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick.

While some features of these programs have been in effect since January 2014, CMS believes it is appropriate to extend the demonstration and continue testing them, because some key underlying program features and demonstration components have changed. To better assess the impact of these program changes, CMS believes that more time is needed to evaluate the demonstration's success, including its impact on beneficiary health. The Dental Wellness Plan was amended only recently, in 2017, and in 2016 the delivery system for all services affected by the demonstration changed to a managed care delivery system. The retroactive eligibility waiver has been in effect for only two years, and CMS is improving the STCs governing evaluation of the entire demonstration, including the retroactive eligibility waiver, for this coming demonstration period. The state was not required to evaluate the retroactive eligibility waiver for the period of October 2017 to December 2019. Now, however, CMS is requiring the state to evaluate the waiver of retroactive eligibility, including the two new exemptions added with this extension, and is also requiring the state's evaluation design to include specific hypotheses for the waiver that relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity; likelihood that beneficiaries will apply for Medicaid when they believe they meet the criteria for Medicaid; enrollment when people are healthy, or as soon as possible after meeting eligibility criteria; and health status (as a result of greater enrollment continuity). The evaluation criteria for the rest of the demonstration have also been updated and made more specific.

It is possible that some of the policies Iowa will continue to test under this extension could result in harmful effects on coverage for some beneficiaries, but CMS has determined that these policies are designed to minimize potential harmful effects. While the premiums and incentives for the ACA expansion population in the demonstration could lead to some beneficiaries with incomes over 100 percent of the FPL losing coverage for failure to pay premiums, the program is designed to make compliance with the requirements achievable. Data considered by CMS as part of its review of the state's extension application indicate that while disenrollments for nonpayment of premiums have fluctuated from November 2015 through June 2019, they have generally remained at or below 7 percent per month of the group of beneficiaries with income over 100 percent of the FPL who are non-exempt and past the initial 13-month grace period,

before accounting for any beneficiaries who reenrolled after losing coverage. Beneficiaries who are disenrolled for nonpayment of premiums can reapply at any time, including immediately after losing coverage. It appears from the state's data that many beneficiaries who lose coverage are reenrolling. And, CMS has authority under the extension STCs to require the state to submit a corrective action plan, which could include temporary suspension of implementation of the demonstration, if monitoring or evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, or unpaid medical claims). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

While the retroactive eligibility waiver could also have potential negative effects on beneficiaries and providers, Iowa has taken steps to minimize that risk. To increase awareness of the waiver of retroactive eligibility and promote the objectives of the Medicaid program (e.g., continuity of coverage and care), Iowa will continue to provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly providers who serve vulnerable populations who may be affected by this policy. This will help to ensure that eligible individuals apply for and receive Medicaid coverage in a timely manner, as well as help to ensure that providers understand how to assist individuals in gaining coverage. The state will continue to employ an outreach strategy in which materials will be made available through various methods such as mailings and on the state's Medicaid website. The state will also continue to provide presumptive eligibility for some eligibility groups, which provides Medicaid coverage for a limited time while a formal Medicaid application is submitted and an eligibility determination is made by the state Medicaid agency. Additionally, with this extension, the new exemptions from the retroactive eligibility waiver will further help to mitigate any harmful effects of the demonstration on vulnerable beneficiaries and on nursing facilities. The extension STCs include specific references to the retroactive eligibility waiver in the requirements for monitoring and evaluating the demonstration, and give CMS authority to require the state to submit a corrective action plan, which could include temporary suspension of implementation of the waiver, if monitoring or evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in provider uncompensated care costs, reported medical debt or unpaid medical bills). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

The demonstration's incentives to enroll as soon as possible and to obtain preventive services and assess health risk have the potential to reduce the cost of providing Medicaid to the beneficiaries subject to these policies, by reducing the incidence of chronic or preventable conditions, and by helping to ensure chronic conditions are well managed. The Dental Wellness Plan is a unique, state-specific approach to providing optional Medicaid benefits while also incentivizing beneficiaries to take measures that are intended to keep the costs of those benefits within reasonable limits. CMS and the state also expect that the demonstration's policy with respect to ED copayments will continue to decrease the use of inefficient and costly care in less

appropriate settings, thereby making beneficiaries less costly to care for and Iowa's Medicaid program more sustainable.

The waiver of NEMT is also likely to help promote Medicaid's objectives by enabling the state to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health coverage, thus improving the fiscal sustainability of the Medicaid program. Improved fiscal sustainability will help Iowa to continue to cover non-mandatory benefits and eligibility groups (such as the ACA expansion population and dental benefits).

The state has been required to evaluate the impacts of the NEMT waiver on access to covered services since the NEMT waiver was first approved, and it will continue to do so under this extension. The results of these evaluations are mixed, but they show some promise that the waiver enables the state to conserve resources that it could potentially use to provide Medicaid services that might be more likely to have a positive effect on beneficiary health and well-being. While certain data suggest that the waiver might have negative effects on access to care, other data suggest the opposite. A 2016 study noted "a significant interaction effect between" being in the group subject to the NEMT waiver "and having an unmet NEMT need on well care visits" like those that beneficiaries must access to avoid premiums. However, the same study noted that the group of beneficiaries who do have the NEMT benefit "experience more unmet NEMT need than those who do not" have the NEMT benefit, and that beneficiaries without the NEMT benefit reported more frequently using assistance from others to travel for health care visits. As a result, the 2016 study noted that it could be premature to reach a conclusion that the waiver is impeding access to care without considering in more detail the experiences surrounding why beneficiaries have an unmet NEMT need. The interim evaluation report submitted with Iowa's extension application suggests that there was no significant difference between the reported unmet need for transportation or in reported worry about the cost of transportation between the group affected by the waiver and a comparison population with access to NEMT. And, the interim evaluation indicated that demonstration beneficiaries reported equal or better access to transportation for health care than the comparison population who received NEMT. In sum, CMS has determined that it is worthwhile to permit the state to continue testing the NEMT waiver, as there are positive indications that the waiver might help Iowa to improve the fiscal sustainability of its Medicaid program, without significant negative effects on beneficiary access to services. By not funding NEMT for a limited number of Medicaid beneficiaries, the state may be able to conserve resources that it could instead use to cover a wider range of benefits and eligibility groups, including non-mandatory groups like the ACA expansion population.

With this extension, CMS will require the state to enhance how it monitors and evaluates the NEMT waiver's impact on beneficiary access to services. The extension STCs require the state to provide monitoring metrics for the NEMT waiver about beneficiary understanding of and experience with transportation in accessing covered services, particularly services that beneficiaries must obtain to avoid premiums. The state must also include evaluation hypotheses about the effects of the NEMT waiver on access to covered services, including access to the services that beneficiaries must obtain to avoid premiums. CMS reserves the right to require the state to submit a corrective action plan, which could include suspending implementation of the NEMT waiver, if monitoring or evaluation data indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increased

difficulty accessing services). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. Additionally, beneficiaries who are medically frail and those eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are exempt from the waiver of NEMT.

In keeping with the state's long-term goals for the demonstration as a whole, which (as noted in the state's historical summary of the demonstration in its extension application) include lowering costs, the state will evaluate the financial impacts of the entire demonstration. The extension STCs require the state to investigate cost outcomes for the demonstration as a whole, with evaluation hypotheses that include but are not limited to: the administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. In addition, the state must use results of hypothesis tests and cost analyses to assess the demonstration's effects on Medicaid program sustainability.

Consideration of Public Comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application and the second occurs at the federal level after the application is received by the Secretary.

Sections 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments.[3]

The federal comment period was open from July 5, 2019 through August 4, 2019. A total of seventeen comments were received during the federal comment period for the Iowa Wellness Plan. Three of the comments were from individuals and fourteen were from organizations. All of the individual comments opposed the NEMT waiver. Seven organizations were in favor of the Iowa Medicaid expansion and none was opposed. Thirteen of the fourteen comments from organizations also opposed the NEMT waiver and none was in favor. Eight organizations were opposed to the waiver of retroactive eligibility and none was in favor. Six organizations opposed premiums and cost sharing; none was in favor. Five organization commenters opposed the wellness exam and HRA; none was in favor. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS' analysis of those issues for the benefit of stakeholders. After

[3] 42 CFR 431.416(d)(2); see also Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11685 (Feb. 27, 2012) (final rule).

carefully reviewing the public comments submitted, CMS has concluded that extending the IWP, including the changes discussed above, is likely to promote the objectives of Medicaid.

Waiver of Retroactive Eligibility

Commenters expressed concern that the waiver of retroactive eligibility will cause financial strain for hospitals and providers because of higher uncompensated costs and also increase the probability that they are no longer able to provide quality care to low-income individuals. Commenters also expressed concern that the waiver has negative impacts on beneficiaries who have low incomes, who have been diagnosed with serious conditions, seniors, and people with disabilities who need long-term services and supports to remain in their homes and communities. According to these commenters, the waiver may cause high medical debt, gaps in coverage, and prevent treatment for those who have been diagnosed with serious conditions. Some commenters expressed concern that the waiver will reduce coverage and impact providers.

CMS has taken these comments into consideration as part of its approval and, with this extension, will require the state to carefully evaluate how the waiver of retroactive eligibility is affecting likelihood of enrollment and enrollment continuity; likelihood that beneficiaries will apply for Medicaid when they believe they meet the criteria for Medicaid; enrollment when people are healthy, or as soon as possible after meeting eligibility criteria; and health status (as a result of greater enrollment continuity). To further mitigate the potential for negative impact on vulnerable populations, under the extension, CMS will not permit the state to waive retroactive eligibility for pregnant women, for women who are 60 days or less postpartum, for infants under age 1, or for children under age 19. Also, under the extension, the state will not waive retroactive eligibility for applicants who are both eligible for Medicaid and nursing facility services based on level of care, and who had been a resident of a nursing facility in any of the three months prior to an application. For beneficiaries who are exempt from the waiver due to eligibility for nursing facility services, retroactive eligibility would be allowed for those particular months in which the applicant was a nursing facility resident. Additionally, the extension STCs give CMS the authority to require the state to submit a corrective action plan, which could include suspending implementation of the demonstration, if monitoring or evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in reported medical debt, unpaid medical bills or provider uncompensated care costs). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

The state and CMS agree that it is essential to ensure that potential recipients understand the importance of timely applying for Medicaid and to ensure that providers and stakeholders who help individuals enroll in Medicaid have an opportunity to update their business practices and information to help ensure individuals apply at the earliest opportunity. To increase awareness of this waiver authority and help ensure that it promotes the objectives of the Medicaid program as intended, Iowa will continue to provide outreach and education to the public and to providers about how to apply for and receive Medicaid coverage. The state also has a hospital presumptive eligibility strategy under which qualified hospitals provide immediate, temporary enrollment into Medicaid until a Medicaid application is submitted, which may help mitigate concerns about

impact on beneficiaries and providers. Additionally, if there was a delay in processing an individual's application, the individual would still receive coverage beginning on the first day of the month in which the application was filed. Providing coverage back to the beginning of the month in which the application was filed will ensure that beneficiaries are not unintentionally penalized if application processing is delayed by no fault of the beneficiary.

Premiums, Cost Sharing, and Coverage Loss

Commenters asserted that the premiums would prevent individuals from maintaining coverage and could result in significantly increased health care costs for the state in the long term. One commenter asserted that in November 2015, 54 percent of the Iowa Medicaid beneficiaries who were required to pay premiums as a condition of eligibility lost coverage for failure to pay. The same commenter noted that Iowa's own survey of disenrolled beneficiaries found that 49 percent of respondents had no health insurance three months after disenrollment.

Through the premium policies in the demonstration, CMS and the state are testing the effectiveness of an incentive structure that attaches penalties to failure to take certain measures, and beneficiaries with household incomes over 100 percent of the FPL (one subset of the larger group required to pay premiums) could be disenrolled for failing to pay required premiums under the demonstration. In reviewing the state's extension application, CMS reviewed data on disenrollments for nonpayment of premiums from November 2015 through June 2019, including data from the state's quarterly and annual monitoring reports, and data obtained by CMS as part of its review of the state's 2016 extension application and the current application, consistent with 42 C.F.R. § 431.412(c)(3). While disenrollments for nonpayment of premiums have fluctuated during this time frame, they have generally remained at or below 7 percent per month of the group of beneficiaries with income over 100 percent of the FPL who are non-exempt and past the initial 13-month grace period, before accounting for any beneficiaries who reenrolled after losing coverage. November 2015 was an outlier month within these data, and this may (at least in part) be because the state appears to have reported several months' worth of disenrollments in that month.

The program's design likely helps to explain why disenrollments have remained relatively low. First, only a subset of the ACA expansion population could be disenrolled for a failure to pay premiums. Beneficiaries with household income at or below 100 percent of the FPL cannot be disenrolled for nonpayment of a premium. Beneficiaries can also avoid the premium requirements entirely by completing an annual wellness exam and HRA. Several groups are exempted from the requirement, including beneficiaries who are medically frail, beneficiaries exempt under CMS regulations at 42 CFR 447.56, and beneficiaries who self-attest to a financial hardship. Iowa has also taken steps to notify beneficiaries of the requirements and how to meet them, and with this extension, CMS is strengthening the STCs to more specifically require this notice. If beneficiaries are disenrolled for nonpayment, they can reapply at any time, and no individual can be denied an opportunity to re-enroll due to nonpayment of a premium.

It appears from the state's data that many beneficiaries who lose coverage are reenrolling, but CMS is requiring the state to conduct additional outreach to help ensure that disenrolled individuals are aware that they can re-enroll. Disenrolled beneficiaries also have the right to

appeal the state's decision (just as is the case for other types of coverage terminations), consistent with all existing appeal and fair hearing requirements. As described in the extension STCs, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Medicaid. The STCs also give CMS authority to require the state to take corrective action as an interim step to withdrawing authority, and an approved corrective action plan could include temporary suspension of implementation of the demonstration, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, sustained trends indicating increases in unpaid medical bills or provider uncompensated care costs). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. Additionally, with the extension, CMS will require the state to conduct outreach to beneficiaries disenrolled for nonpayment, to help ensure that they are able to reenroll as soon as possible.

Commenters also stated that many beneficiaries did not know that they had to complete the wellness exam and HRA, or pay the premiums, and that, of those who knew, most did not know about the option to claim a hardship. Commenters also expressed concern that the demonstration would continue to impose monthly premiums and cost sharing on very low income people, act as a barrier to accessing care, lead to adverse health outcomes, maintain a complicated and poorly understood requirement to engage in a wellness exam and HRA, and cause financial hardship. The interim evaluation findings submitted with the state's extension application were not final and the final evaluation report may provide a more complete picture of the consequences of the premiums policy and how well beneficiaries understand it. The preliminary findings in the interim evaluation are mixed and at times contradictory. Some results seem to indicate the program is imposing achievable incentives, while others suggest that there might be problematic gaps in beneficiary understanding of the program, or that beneficiaries are not responding to the state's incentives. For example, some of the findings noted in the Healthy Behaviors Interim Report from April 2019 are based on an enrollee survey, which indicates that of 462 respondents who received an invoice for a monthly premium, a majority 298 (64.5 percent) stated that they were able to pay their premium. Nonetheless, other findings from the same survey suggested that just under half of beneficiaries (41.75 percent) had paid their premiums. Other findings showed low HRA completion rates and low rates for completion of both a wellness visit and an HRA, as noted in the comments. While CMS acknowledges the data cited in these comments, there are also several positive key findings from the IWP Interim Evaluation, such as an increase in wellness exam and HRA completion rates for IWP beneficiaries with income over 100 percent of the FPL (those who are subject to a disenrollment penalty) since initial implementation. IWP beneficiaries with lower incomes who accessed preventive services or completed an HRA had significantly lower rates of non-emergent ED visits, and the proportion of lower income IWP beneficiaries with a return emergency department visit was lower in the group that completed an HRA or preventive services in the prior year.

Nonetheless, CMS has taken the commenters' concerns into consideration in the STCs for this extension approval period. The state is required to provide outreach and education to beneficiaries and providers to inform them of the incentives that could be used both for purposes

of avoiding premiums, for other health-related purposes and to better understand the consequence of disenrollment if premiums due are not paid. Furthermore, CMS is working with the state to strengthen the evaluation for the overall period of performance, and has incorporated specific monitoring and evaluation requirements into the extension STCs to help CMS and the state better and more conclusively understand the effectiveness and consequences of these policies. For example, with this extension, CMS has incorporated specific requirements for evaluating the incentives and premiums, including beneficiary understanding of and experience with premiums as an incentive, the interface between incentives to seek out preventive care and premiums, and consequences of these demonstration policies, including non-compliance with premiums and incentives, on coverage (including employer-sponsored health insurance and no coverage for those who separate from the demonstration) and health outcomes. CMS believes that with program maturity and ongoing outreach and education, the overall goals of these policies will be achieved. The premiums and cost-sharing features of the demonstration are designed to incentivize the uptake of preventive services, which could improve beneficiary health and thereby reduce the costs of providing coverage, thus improving the financial sustainability of Iowa's Medicaid program.

Finally, one commenter stated that Congress has the authority to change flexibilities available to states to charge premiums, not HHS. The commenter added that the Medicaid statute prohibits states from charging premiums to individuals with household incomes below 150 percent of FPL. Section 1115 allows the Secretary to waive any of the requirements of section 1902 of the Act for purposes of researching innovative approaches to delivering Medicaid benefits and services, if the Secretary determines that the waiver would be likely to assist in promoting Medicaid statutory objectives. The provisions that can be waived include section 1902(a)(14), which would otherwise require a state to follow Medicaid statutory provisions regarding beneficiary premiums.

NEMT

Commenters expressed the view that NEMT is a critical benefit that supports regular use of health care services for people with mental health conditions, low incomes, chronic conditions, seniors, and residents of rural communities. Commenters were concerned that waiving NEMT could cause delayed or missed care for patients and lead to the increased risk of hospitalization, nursing-home admission, institutionalization, and higher cost for emergency medical transportation and treatment for individuals. Commenters were also concerned that waiving NEMT could have a negative impact on all transit providers and community beneficiaries in Iowa by reducing routes, workforce, and vehicle fleets that provide non-Medicaid rides for other vulnerable populations such as people with physical disabilities, developmental disabilities, and the elderly. To limit the impact on vulnerable beneficiaries, Iowa chose to apply this waiver of NEMT to only the ACA expansion population. Also, the state exempts the beneficiaries who are medically frail and those eligible for EPSDT services from the NEMT waiver. Before January 1, 2014, the effective date of the original demonstration and NEMT waiver, Iowa did not provide Medicaid coverage to this population and therefore this population did not previously receive NEMT, so providers are no worse off than they were prior to ACA expansion and the approval of the waiver. CMS thus determined that the state has taken steps to minimize the impact of the waiver on vulnerable beneficiaries and providers.

Additionally, as discussed above, monitoring data continue to indicate that the NEMT waiver is not significantly impeding the affected population's access to care. According to the Iowa Health and Wellness Plan Evaluation Interim Summative Report, April 2019, the reported unmet need for transportation was not statistically different for Medicaid beneficiaries receiving NEMT (12 percent) and the ACA expansion population subject to the waiver of NEMT (11 percent). There was no statistical difference between Medicaid beneficiaries receiving NEMT and the ACA expansion population subject to the waiver of NEMT in reported worry about the cost of transportation, with around 8 percent of each group reporting that they worried "a great deal" about their ability to pay for the cost of transportation to or from a health care visit. Nonetheless, the extension STCs give CMS the right to require the state to submit a corrective action plan, which could include temporary suspension of implementation of the NEMT waiver, if monitoring or evaluation data indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increased difficulty accessing services). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

General Comments

A commenter felt that the demonstration would curtail the EPSDT benefit for 19- and 20-year olds. According to the STCs established between the state and CMS, all beneficiaries under 21 years of age will continue to be eligible through the state plan for medically necessary services, including dental services and NEMT, in accordance with federal EPSDT requirements. Regular medical checkups, information about growth, diet and development immunizations (shots) like measles and mumps, regular vision and hearing checkups and regular dental checkups are covered.

One of the commenters expressed an opinion that the application should not be considered under what the commenter referred to as "the Fast Track review process" because the application does not acknowledge the results of the interim evaluations, which show that the demonstration is causing people to lose coverage and is therefore inconsistent with the objective of the Medicaid program to provide coverage to low-income individuals. CMS reviewed the renewal application under the section 1115(f) authority because the IWP demonstration is currently operating under a section 1115(e) extension, and thus, the state's renewal application is eligible for consideration under section 1115(f), which is an expedited process but not what CMS typically considers to be a "Fast Track" process. The analyses presented in the interim evaluation report are largely descriptive in nature, and therefore, findings reported should be interpreted with caution, as these do not indicate a causal relationship. It is expected that future evaluation of the demonstration, resulting from the more rigorous evaluation expectations set in the extension STCs, will provide a more robust assessment of the effectiveness of all demonstration policies. Initial findings appear to suggest that there might have been some improvements in care and access. However, CMS believes that the possible results and effects of the policies have not yet been evaluated adequately, and thus CMS has determined that the state should continue to evaluate whether the potential long-term benefits of the demonstration may outweigh any potential negative results that commenters are concerned about. As discussed above, CMS reviewed data on disenrollments for nonpayment of premiums from November 2015 through June 2019 as part of

its review of the state's extension request, and determined that disenrollments for nonpayment have generally remained at or below 7 percent per month of the group of beneficiaries with income over 100 percent of the FPL who are non-exempt and past the initial 13-month grace period, before accounting for any beneficiaries who reenrolled after losing coverage. Meanwhile, as also discussed above, the incentives created by the demonstration show some promise. In any event, CMS has taken steps to strengthen beneficiary protections with this approval.

One commenter expressed that the demonstration extension should not be approved because it is not a pilot or experiment, and continuing the waiver authorities would extend the project well beyond the necessary timeframe for understanding the impact on the Medicaid program. Although this approval is for an extension, there have been underlying program changes, such as the move to comprehensive managed care. By requiring mandatory enrollment in managed care, the state sought to improve care coordination among providers and incentivize active management of beneficiaries' health care. Under the managed care delivery system, MCOs are responsible for delivering all benefits affected by the demonstration in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies. There have also been changes to the Dental Wellness Plan, and the waiver of retroactive eligibility was added in 2017 and is being updated with this approval to include new exemptions. CMS believes that a new period of performance is required to sufficiently assess results and fully understand the impact of the demonstration. Moreover, because CMS has updated the monitoring and evaluation sections of the STCs to better align those sections with CMS' current approach to monitoring and evaluation for section 1115 demonstrations, the state and CMS will be better positioned during the extension approval period to measure and track the demonstration's impact on Iowans affected by the policies in the demonstration.

Some commenters expressed concern that Iowa's extension application did not include estimates of enrollment, annual aggregate expenditures, or impact on program enrollment as outlined in federal regulations. Again, in reviewing the state's extension application, CMS reviewed data on disenrollments for non-payment of premiums from November 2015 through June 2019, including data from the state's monitoring reports, and data obtained by CMS as part of its review of the state's 2016 extension application and the current application, consistent with 42 CFR. 431.412(c)(3). While disenrollments for nonpayment of premiums have fluctuated during this time frame, they have generally remained at or below 7 percent per month of the group of beneficiaries with income over 100 percent of the FPL who are non-exempt and past the initial 13-month grace period, before accounting for any beneficiaries who reenrolled after losing coverage.

One commenter specifically noted that under 42 CFR 431.412(c)(2)(v), the state is required to provide a historical and projected financial analysis, which would necessarily require enrollment numbers and estimates. Section II of the preamble for the April 27, 2012 final rule on transparency and public notice procedures for section 1115 demonstrations indicates that the purpose of the requirement for inclusion of financial data is to support analysis needed to establish budget neutrality. In most cases, States must show on the basis of reasonable with- and without-waiver cost projections that the proposed demonstration will not cost the Federal government more than the program could have cost in the demonstration's absence. As

discussed in CMS' August 22, 2018 State Medicaid Director Letter on "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects," for demonstrations that include only waiver authorities under section 1115(a)(1), CMS sometimes determines that the authorized waivers will not result in an increase in federal Medicaid spending on medical assistance, and deems the demonstration to be budget neutral without carrying out the financial calculations that are generally associated with budget neutrality. Iowa's demonstration was originally approved, and was similarly requested to be extended, as a section 1115(a)(1) "waiver only" demonstration, and the waiver authorities granted for the demonstration are unlikely to result in any increase in federal Medicaid expenditures for medical assistance. In alignment with the intended purpose of 42 CFR 431.412(c)(2)(v), Iowa's extension application did not need to include a financial analysis of historical or projected expenditures as a "waiver only" demonstration that has been deemed budget neutral pursuant to CMS policy. Accordingly, CMS determined that Iowa's application met the minimum standards set forth in 42 CFR 431.412(c) for a complete demonstration extension application and that CMS could proceed with the federal approval process. Nonetheless, as discussed above, as part of its review of the state's application, CMS obtained from the state and reviewed data on disenrollments for nonpayment of premiums.

Other Information

CMS approval of this demonstration is also conditioned upon compliance with these STCs and waiver authorities that define the nature, character, and extent of anticipated federal involvement in this demonstration project. This award is subject to the state's written acknowledgement of the award and acceptance of the enclosed STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Wanda Boone-Massey, who can be contacted to answer any questions concerning the implementation of this demonstration. Ms. Boone-Massey's contact information is as follows:

Ms. Wanda Boone-Massey
Division of Medicaid Expansion Demonstrations
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Wanda.Boone-Massey@cms.hhs.gov

Official communications regarding demonstration program matters should be sent simultaneously to Ms. Wanda Boone-Massey and to Mr. James Scott, Director, Division of Medicaid Field Operations North. Mr. Scott's contact information is as follows:

Mr. James Scott
Division of Medicaid Field Operations North
Regional Operations Group
Centers for Medicare & Medicaid Services
Richard Boling Federal Building

601 E. 12th St, Room 355
Kansas City, MO 64106-2808
Email: James.Scott1@cms.hhs.gov.

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

Calder Lynch
Acting Deputy Administrator and Director

Enclosures

cc: James Scott, Director, Division of Medicaid Field Operations North