

**Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs**

May, 2013

Table of Contents

Proposal

Facesheet

Section A: Program Description

Part I: Program Overview

- A. Statutory Authority
- B. Delivery Systems
- C. Choice of MCOs, PIHPs, PAHPs, and PCCMs
- D. Geographic Areas Served by the Waiver
- E. Populations Included in Waiver
- F. Services

Part II: Access

- A. Timely Access Standards
- B. Capacity Standards
- C. Coordination and Continuity of Care Standards

Part III: Quality

Part IV: Program Operations

- A. Marketing
- B. Information to Potential Enrollees and Enrollees
- C. Enrollment and Disenrollment
- D. Enrollee Rights
- E. Grievance System
- F. Program Integrity

Section B: Monitoring Plan

Part I: Summary Chart

Part II: Monitoring Strategies

Section C: Monitoring Results

Section D: Cost Effectiveness

Part I: State Completion Section

Part I: Appendices D1-7

Instructions – see Attachment 1

Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of Iowa requests a waiver under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is the Iowa Plan for Behavioral Health. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

- initial request for new waiver. All sections are filled.
 - amendment request for existing waiver, which modifies Section/Part D2.S, Program History, Section D and appendices.
 - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
 - Document is replaced in full, with changes highlighted
 - renewal request
 - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
 - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
 - Section A is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
- For a period of five (5) years; effective July 1, 2011 and Section B is
- replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Monitoring Plan from the previous waiver period.

_____ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver renewal is requested for a period of 5 years; effective July 1, 2011 and ending June 30, 2016

State Contact: The State contact person for this waiver is Dennis Janssen and can be reached by telephone at (515) 256-4643, or fax at (515) 725-1360, or e-mail at DJansse@dhs.state.ia.us.

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The following tribal representatives were sent a notification of the changes to this existing waiver with a request to contact Dennis Janssen if there were any questions or comments with regard to this renewal. It is noted that this waiver has been in place since 1999 and is considered a mature program which has worked successfully with tribal authorities in the past. The notification was sent on April 4, 2013. No comments were received but the Department will encourage and address submission of any comments between the submission of this amendment and CMS approval.

Rudy Papakee, (Sac & Fox Nation of the Mississippi in Iowa)
Amen Sheridan Sr. (Omaha Tribe of Nebraska);
Arlan Whitebird (Kickapoo Tribe in Kansas);
Brown, Shoshonis; Dickey, Ashley; Gonzales, Mirza; Frank Black Cloud (IHS/ABR/MSK);
Jan Colwell, Rebecca Crase, Riannon Clausen (Ponca Tribe Admin.);
John Blackhawk (Winnebago Tribe of Nebraska);
Lee, Don; Leon Campbell (Iowa Tribe of Kansas and Nebraska);
Lisa Chamberlain, Ricky Trobaugh (Winnebago Tribe of Nebraska);
Rieb, Kathy; Roger Trudell (Santee Sioux Tribe);
Steve Ortiz (Prairie Band Potawatomi Nation);
Suniga, Lisa; Twen Barton (Sac & Fox Nation of Missouri);
Medina, Pat; Parker, Audrey L. (IHS/ABR);

It is noted that only the Sac & Fox Nation of the Mississippi have a settlement in the state of Iowa. However, it is possible that other tribes would find this waiver of interest. Therefore, Iowa believes that the best potential for assuring that Native Americans are fully and completely apprised of activity such as this is to allow notification to as many disparate tribal organizations as is possible within the CMS Region (VII).

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

- The Iowa Plan was created in 1999 joining mental health services and substance abuse services in one Contract for administration of Behavioral Health. The Contract was for managed care creating services for members that were not available under Medicaid fee for service. The services would be cost effective with the savings over fee for services payments for care. Currently, Magellan Behavioral Care of Iowa, Inc. contracts to provide the administration. The Medicaid program today operates under a 1915b waiver for substance abuse and mental health granted by CMS.
- The Iowa Plan provides for the cooperative administration between Medicaid behavioral services and the Iowa Department of Public Health (IDPH) state and Federal block grant substance abuse services. While managing the two programs allows for administrative efficiencies, the Iowa Plan contractor is required to maintain and document separate funding streams, service requirements, and eligible populations for the two areas of responsibility: (1) Medicaid, (2) IDPH substance abuse treatment services
- The Medicaid program pays the contractor a capitated amount for each Medicaid eligible person, regardless of his or her need for mental health or substance abuse services. Providers are then paid on a fee-for-service basis by the contractor for authorized services based on a contracted fee schedule.
- The public health program pays the contractor a fixed amount of the grant per month for services provided to non-Medicaid consumers. Providers are required to serve a minimum number of clients and are additionally required to serve all eligible persons in their designated service area. In turn, the contractor pays providers even monthly installments of the area's fixed grant. Providers are not required to request authorization for services to non-Medicaid consumers.
- The Iowa Plan's Quality Assurance Program was awarded full accreditation status by the American Accreditation Health Care Commission/URAC in November 1997. The contractor has maintained accreditation since that time, with the most recent review resulting in full accreditation effective through June 1, 2013.
- Effective December 31, 2001, the PIHP successfully completed the process of becoming licensed by the Division of Insurance in the state of Iowa as a Limited Service Organization.
- The Iowa Plan was re-procured effective July 1, 2004, after a competitive process. Magellan Behavioral Care of Iowa won the bid again. A principle of the program under this contract is Continuous Quality Improvement. Toward this end, the new contract has new policies in place to better administer behavioral health services.

- Most recently, The Iowa Plan was re-procured with an effective date of January 2010 through a competitive RFP process. Magellan Behavioral Care of Iowa was awarded the Contract. This RFP emphasized recovery orientation, emphasis on emergency services, as well as other initiatives, some to be phased in during the term of the Contract. With this re-procurement comes a requirement that the contractor become NCQA accredited within the first contract period. The contractor is moving toward that goal.
- Through the use of savings in their waiver, Iowa is able to provide more services to Medicaid beneficiaries through the Iowa Plan than under fee-for-service. For example, under fee-for-service Iowa was only able to provide inpatient and outpatient substance abuse hospital services. Under the managed care waiver, Medicaid beneficiaries can now also receive community based substance abuse treatment services developed at a less costly, less restrictive and more effective alternative to hospitalization.
- Consistent with waiver requirements for Performance Improvement Projects, Magellan has implemented Intensive Care Management (ICM) and an Outcomes Project. ICM is an enhanced form of Joint Treatment Planning through which enrollees with multiple current needs choose to participate in focused, recovery-oriented service planning and self-directed care planning. Through the Outcomes Project, enrollees and their therapist input information on current symptoms and strengths into a user-friendly dedicated computer system to support immediate, focused, consumer-directed treatment planning.
- The Iowa Legislature directed, in the 2010 session that the Medicaid program initiate a stakeholder committee to develop a transition plan to move remedial services into the Iowa Plan. This comes about so that the Iowa Plan, which manages the utilization of mental health services, could coordinate the remedial services with the more traditional mental health services covered under the state plan but provided through this waiver. Additionally, the Iowa Plan contractor may coordinate B3 services so that the full range of treatment for those receiving remedial services can be utilized to maximize the service array available to Medicaid members. This committee met numerous times in the late summer and fall of 2010 and sent a report on its progress to the legislature as it was directed to do, in December of 2010. This committee continues to function to lead and assist the transition of remedial services into the Iowa Plan which is noted as a part of this waiver to be effective July 1, 2011. This committee also recommended that the remedial services be 're-branded' as Behavioral Health Intervention Services to more accurately reflect the services being provided.
- The Department notes that psychiatric medical institutions for children (PMIC) has been transitioned into the Iowa Plan as of July 1, 2012. This is also reflected in the cost effectiveness sections of this renewal application and is also driven by legislative instructions.

- In 2007 the Department initiated, with federal approval, Habilitation Services under a 1915(i) HCBS state plan amendment. Effective July 1, 2013 the Department intends to put this state plan service into the realm of services covered by the Iowa Plan under this waiver. This change (amendment) is described in the cost effectiveness sections of the amendment request submitted in 2013 and with the above anticipated start date.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- 1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- 1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- 1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- 1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- MCO
- PIHP
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. ___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. X **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
- c. X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d. X **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. ___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a. ___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. X **PIHP:** Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

X The PIHP is paid on a risk basis.

___ The PIHP is paid on a non-risk basis.

c. ___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.

___ The PAHP is paid on a non-risk basis.

d. ___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan

___ is different than stipulated in the state plan (please describe)

f. ___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

Response

The State conducted another competitive procurement for the Iowa Plan in early 2009 using a Request for Proposal that was formally advertised and targeted all qualified bidders. Iowa Medicaid selected Magellan Behavioral Health of Iowa as the best bidder in that process. Magellan is the previous contractor and remains the contractor as of this submission. The contract expires on June 30, 2013 and has the option for 3 1-year extensions.

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

Response

The State operates the Iowa Plan under a single state-wide PIHP. The enrollee may choose their provider within the Iowa Plan Contractor's network. Medicaid enrollees may choose to access Iowa Plan services through any network provider who offers the appropriate level of care. The State requires the Iowa Plan PIHP to maintain a provider panel that is sufficient to meet the needs of the enrolled population.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- Two or more PIHPs.
- Two or more PAHPs.
- Other: (please describe)

3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting

Beneficiaries will be limited to a single provider in their service

area (please define service area).

Response:

Beneficiaries will be limited to using providers who are in the network of the Iowa Plan contractor, and will have choice of providers in that network. The service area in this case is the state.

___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

Statewide -- all counties, zip codes, or regions of the State

Less than Statewide

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

| City/County/Region | Type of Program (PCCM, MCO, PIHP, or PAHP) | Name of Entity (for MCO, PIHP, PAHP) |
|--------------------|--|--------------------------------------|
| | | |
| | | |
| | | |

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

Mandatory enrollment
 Voluntary enrollment

Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

Mandatory enrollment
 Voluntary enrollment

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Mandatory enrollment
 Voluntary enrollment

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

Mandatory enrollment
 Voluntary enrollment

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

Mandatory enrollment
 Voluntary enrollment

Note: This population was added effective July 1, 2010 as per the previous waiver renewal submission.

Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

Mandatory enrollment
 Voluntary enrollment

TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

Mandatory enrollment
 Voluntary enrollment

* Other populations

* Medicaid population covered by the program of Medicaid Eligibility for Persons with Disability (MEPD)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance--Medicaid beneficiaries who have other health insurance.

Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

Response:

The following are exceptions to excluded populations for the retroactive period: Retroactive enrollment for children in substance abuse PMICs and MHI child/adolescent treatment programs is covered under the Iowa Plan. Also, retroactive eligibility for MEPD applicants for up to three months prior to the date of application is approved.

Other (Please define):

The following Medicaid members are excluded from enrollment:

- Persons eligible for Medicaid as Medically Needy with a spenddown.
- Persons who reside in Glenwood State Resource Center or Woodward State Resource Center.
- Persons who have a limited Medicaid benefit package; Qualified Medicare Beneficiaries, Family Planning beneficiaries, Specified Low Income Medicare Beneficiaries, Qualified Disabled Working Person, Presumptive eligible, and Illegal Aliens.
- Persons enrolled in the PACE program.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

- X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
 - Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
 - Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

Response

Family Planning Services are not included in this Waiver. These services are covered under the fee-for-service methodology for these Medicaid members.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

- X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

The State will pay for all family planning services, whether provided by network or out-of-network providers.

Other (please explain):

Family planning services are not included under the waiver.

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not

required to provide FQHC services to the enrollee during the enrollment period.

- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Response

Currently there are several FQHC s enrolled with the Contractor. They serve av small number of counties. Historically and at the present time, most FQHCs in Iowa do not provide primary mental health services. However, enrollees have the choice of providers within the Contractor’s network and can choose one of the FQHCs if they wish.

- The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

- The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

- This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

RESPONSE:

The list of B (3) services follows:

| <i>Service</i> | <i>Description of Service</i> | <i>Provider Type/Qualifications</i> | <i>New or Renamed but previously provided under waiver</i> | <i>Duplicative of other Medicaid State Plan Service</i> <i>Y or N</i> | <i>Populations Eligible</i> | <i>Geo-graphic Availability</i> | <i>Reimbursement Method</i> |
|--------------------------------------|--|---|--|--|--|---------------------------------|-----------------------------|
| Intensive Psychiatric Rehabilitation | Rehabilitation and Support Services are comprehensive outpatient services based in the individual's home or residence and/or community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persisting mental disorders, and/or complex symptoms who require multiple mental health and psychosocial support services. Such services are active and rehabilitative in focus, and are initiated and continued when there is a reasonable likelihood that such services will lead to specific observable improvements in the individual's functioning. | <i>Community Mental Health Centers, (CMHCs) Other Agencies providing Mental Health Services. Accredited organizations under Iowa Administrative Code Chapter 24</i> | <i>Same as previous waiver</i> | <i>N</i> | <i>Iowa Plan Medicaid eligible persons age 18 or older</i> | <i>State Wide</i> | <i>Negotiated rates</i> |
| Community Support | Required Service: Community Support Services (CSS) are provided under the Iowa Plan to adults with a severe and persistent mental illness. These services are designed to support individuals as they live and work in the community. These services address mental and functional | <i>Community Mental Health Centers Accredited organizations under Iowa Administrative Code Chapter 24</i> | <i>Same as previous waiver</i> | <i>N</i> | <i>Iowa Plan Medicaid eligible persons age 18 or older</i> | <i>State Wide</i> | <i>Negotiated rates</i> |

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| | <p>disabilities that negatively affect integration and stability in the community. CSS staff attempt to reduce or manage symptoms/reduced functioning that result from a mental illness.</p> <p>CSS providers are expected to have knowledge and experience in working with this population. Staff should have the ability to create relationships with this population that provide a balance between support of the mental illness and allow for maximum individual independence.</p> <p>Community support program components include:</p> <ol style="list-style-type: none"> a. Monitoring of mental health symptoms and functioning/reality orientation b. Transportation c. Supportive relationship d. Communication with other providers e. Ensuring consumer attends appointments/obtains medications f. Crisis intervention/developing crisis plan g. Coordination and development of natural support systems for mental health support | | | | | | |
| Peer Support | <p><i>Peer Support and Parent Peer Support services. The services provided to Eligible Persons by other mental health consumers who are specifically trained to</i></p> | <p><i>Peer Support Specialists at Accredited organizations contracted using Magellan credentialing</i></p> | <p><i>Now paid as Peer Support – a clubhouse could be the site of the Peer Support Service</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible persons age 18 or older</i></p> <p><i>Parent Peer</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |

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| | <p><i>provide peer support services. Services are targeted toward the support of persons with a serious and persistent mental illness or substance abuse. Peer support services focus on individual support and counseling from the perspective of a trained peer, and may also include service coordination and advocacy activities as well as rehabilitative services. Peer support services are initiated when there is a reasonable likelihood that such services will benefit an Eligible Person's functioning and assist him or her in maintaining community tenure.</i></p> | <p><i>standards and Peer Support Specialist has received Georgia Model training.</i></p> | | | <p><i>Support is to provide support to the parents of children or adolescents.</i></p> | | |
| Residential substance abuse treatment | <p><i>See below – to III.1, III.3 & III.5</i></p> | | | | | | |
| Integrated Services and Supports (Wrap-around services) | <p><i>Informal services/supports that are offered by providers, family/friends and other members of the natural support community.</i></p> <p><i>The services/supports must be integrated into the treatment plan. These interventions help individuals to remain in or return to their home and limit the need for more intensive out-of-home mental health treatment. Integrated services and supports are specifically tailored to an individual consumer's needs at a particular point in time, and are not a set menu of services.</i></p> <p><i>A joint treatment</i></p> | <p><i>Entire provider network contracted using Magellan credentialing standards</i></p> | <p><i>New name consistent with RFP and Contract</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible persons</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |

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| | <p>planning process may identify the need for integrated services/supports. The consumer/family member must lead the planning process and other members of the team giving their input as well. Individual contacts with the consumer/family may also identify the need.</p> <p>Ideally this provides more flexibility to provide consumers unique services to address the mental health needs to augment and complement those provided through other funders and systems. There is natural support involvement that may require reimbursement and at other times be part of the family process.</p> <p>Examples include:</p> <p>Peer mentor Family support person Transportation for treatment Hotel for parent to attend treatment of child</p> | | | | | | |
| Respite | <p>Required Service: In/Out of Home Respite are community and home-based services that can be provided in a variety of settings. Respite care is a brief period of rest and support for individuals and/or families. Respite care is intended to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current</p> | <p><i>Hospitals, agencies, CMHCs contracted using Magellan credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code Chapter 24</i></p> | <p><i>Same as previous waiver</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible persons</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |

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| | <p>problems/issues related to a mental health diagnosis. Respite may be provided for up to 72 hours and can be planned or in response to a crisis.</p> <p><i>A comprehensive respite program must provide or ensure linkages to a variety of residential alternatives for stabilizing and maintaining consumers who require short-term respite in a safe, secure environment with twenty four hour supervision outside a hospital setting. Respite is a community-based alternative to inpatient hospitalization that provides a temporary, safe, and secure environment with a flexible level of supervision and structure. These services are designed to divert individuals from an acute hospitalization to a safe environment where monitoring of medical and psychiatric symptoms can occur.</i></p> | | | | | | |
| <p>Level III.1. Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Abuse</p> | <p><i>From ASAM Patient Placement Criteria: Level III services offer organized treatment services that feature a planned regimen of care in a 24 hour residential setting. All Level III programs serve individuals who, because of their specific functional deficits, need a safe and stable environment in order to develop their recovery skills. The sublevels within Level III exist on a continuum ranging from the least intensive to the most intensive</i></p> | <p><i>Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125</i></p> | <p><i>Same as previous waiver</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible age 18 and over</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |

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| | <p><i>medically monitored intensive inpatient services. The term “clinically managed” (Levels 1-3 have relatively stable problems in Axis I and/or less stable problems in Axis II of the DSM.</i></p> <p><i>Level III.1 – at least 5 hours/week of treatment plus the structured recovery environment.</i></p> | | | | | | |
| Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Treatment Substance Abuse | <p><i>Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 are designed to treat persons who have significant social and psychological problems. Services are based on a therapeutic treatment community.</i></p> <p><i>A step-down or alternative to Level III.7.</i></p> | <p><i>Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125</i></p> | <p><i>Same as previous waiver</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |
| Level III.3 & 5 Clinically Managed Medium/High Intensity Residential Treatment Substance Abuse Hospital Based | <p><i>Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 are designed to treat persons who have significant social and psychological problems. Services are based on a therapeutic treatment community.</i></p> <p><i>A step-down or alternative to Level III.7.</i></p> | <p><i>Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125</i></p> | <p><i>Same as previous waiver</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |
| Level III.7 Substance | <p><i>24-hour professionally directed evaluation, observation, medical</i></p> | <p><i>Substance Abuse programs licensed by Iowa</i></p> | <p><i>Same as previous waiver</i></p> | <p><i>N</i></p> | <p><i>Iowa Plan Medicaid eligible</i></p> | <p><i>State-wide</i></p> | <p><i>Negotiated rates</i></p> |

| | | | | | | | |
|-----------------------------------|--|--|--------------------------------|----------|------------------------------------|-------------------|-------------------------|
| Abuse Residential Community based | <i>monitoring and addiction treatment in a licensed substance abuse facility</i> | <i>Department of Public Health under Iowa Code Chapter 125</i> | | | | | |
| Community Reinvestment Fund | <i>2.5% of the monthly capitation payments are placed into the Community Reinvestment Account. 30% can be used for education and 70% used for services that will be directed to Iowa Plan Enrollees. Use of the funds is upon the approval of the Departments, to further access to care, best practices and goals of recovery and coordination.</i> | <i>Entire provider network contracted using Magellan credentialing standards</i> | <i>Same as previous waiver</i> | <i>N</i> | <i>Iowa Plan Medicaid eligible</i> | <i>State-wide</i> | <i>Negotiated rates</i> |

7. Self-referrals.

X The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Response:

Outpatient mental health visits, including assessments, individual therapy, Group therapy and family therapy do not require prior authorization. Similarly, these same substance abuse services do not require prior authorization nor do substance abuse intensive outpatient or halfway house (ASAMIII.1) services.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. PCPs (please describe):

2. Specialists (please describe):

3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

c. ___ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. ___ Mental Health (please describe):

6. ___ Substance Abuse Treatment Providers (please describe):

7. ___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

- The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.
- d. The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

| Providers | # Before Waiver | # In Current Waiver | # Expected in Renewal |
|--|------------------------|----------------------------|------------------------------|
| Pediatricians | | | |
| Family Practitioners | | | |
| Internists | | | |
| General Practitioners | | | |
| OB/GYN and GYN | | | |
| FQHCs | | | |
| RHCs | | | |
| Nurse Practitioners | | | |
| Nurse Midwives | | | |
| Indian Health Service Clinics | | | |
| Additional Types of Provider to be in PCCM | | | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

*Please note any limitations to the data in the chart above here:

- e. ___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.
- f. ___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

| <i>Area(City/County/Region)</i> | <i>PCCM-to-Enrollee Ratio</i> |
|---------------------------------|-------------------------------|
| | |
| | |
| | |

| | |
|--|--|
| | |
| | |
| <i>Statewide Average: (e.g. 1:500 and 1:1,000)</i> | |

g. ____ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

- a. The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
- b. **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

Response

The PIHP is a behavioral health care carveout program with a narrow focus of benefits. While the state does not require the additional services, many of the required activities are required of the PHIP, when the focus is on mental health or substance abuse treatment.

The PIHP allows direct access to specialist care for mental health and substance abuse treatment services. State requires the PIHP to have a panel of providers sufficient to meet the needs of the enrolled population who are appropriately

licensed, certified, or accredited who meet the PHIP's credentialing criteria, who agree to the standard contract provisions and who wish to participate. Because Iowa Plan is a mental health and substance abuse carve out, the requirement to use specialists is inherent in the requirement to provide covered benefits.

In order to identify enrollees with special mental health care or substance abuse treatment needs, the PIHP is required to identify high risk or high needs clients, and enrollees who access mental health or substance abuse treatment services and meet certain criteria, such as inpatient readmission due to medication complication, IV drug user, pregnant with SA treatment needs, currently suicidal or homicidal, other.

PIHP is required to conduct Joint Treatment Planning conferences for enrollees who need a course of treatment that requires coordination among various systems of care. Joint Treatment Planning conferences involve the client (required) and their parent(s) if the client is a child, providers, "helper-agency" case workers such as DHS social worker or juvenile court staff and others involved with the client's care. These entities are used to define treatment team responsibilities, to develop treatment plans, to build consensus among all involved, and to coordinate funding for services.

The PIHP identifies Iowa Plan Enrollees who demonstrate a need for high levels of services or who are at risk of high utilization using predictive modeling. Predictive modeling uses customized, data-driven strategies to match clients with appropriate clinical interventions. The PIHP uses available data and predictive algorithms to predict future risk and need for intensive levels of care. The PIHP applies predictive high-risk algorithms to variables such as age, gender, behavioral diagnosis, medical co-morbidities, dual diagnosis, prior higher level of care utilization, and others. Specialized algorithms exist for both adults and children (ages 18 years or less), and program-specific algorithms reflect special population differences. The PIHP uses the data to develop population-specific strategies and interventions that enhance services. Data is also used to proactively identify individuals who are at high risk to develop individual strategies for ongoing treatment planning and coordination through Intensive Care Management (ICM) program, joint treatment planning, collaboration with caseworkers (targeted case managers, child welfare, juvenile court services), and with providers who are providing services in the community.

- c. X **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

Response

The State requires the contractor to implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to

identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

- d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. In accord with any applicable State quality assurance and utilization review standards.
- e. **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. Each enrollee is receives **health education/promotion** information. Please explain.
- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.

- f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
 - g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
 - h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
 - i. ___ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on 08-20-07.

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

| Program | Name of Organization | Activities Conducted | | |
|---------|--|----------------------|----------------------|---------------------|
| | | EQR study | Mandatory Activities | Optional Activities |
| MCO | | | | |
| PIHP | Telligen - McCurrySchwarz Consulting | X | X | |

2. **Assurances For PAHP program.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___ Provide education and informal mailings to beneficiaries and PCCMs;

2. ___ Initiate telephone and/or mail inquiries and follow-up;

3. ___ Request PCCM's response to identified problems;

4. ___ Refer to program staff for further investigation;

5. ___ Send warning letters to PCCMs;

6. ___ Refer to State's medical staff for investigation;

7. ___ Institute corrective action plans and follow-up;

- 8. ___ Change an enrollee's PCCM;
- 9. ___ Institute a restriction on the types of enrollees;
- 10. ___ Further limit the number of assignments;
- 11. ___ Ban new assignments;
- 12. ___ Transfer some or all assignments to different PCCMs;
- 13. ___ Suspend or terminate PCCM agreement;
- 14. ___ Suspend or terminate as Medicaid providers; and
- 15. ___ Other (explain):

c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

- 1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
- 2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
- 3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ___ Initial credentialing
 - B. ___ Performance measures, including those obtained through the following (check all that apply):
 - ___ The utilization management system.

- ___ The complaint and appeals system.
- ___ Enrollee surveys.
- ___ Other (Please describe).

- 4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
- 5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
- 6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
- 7. ___ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

- The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. **Scope of Marketing**

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.
3. The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

Response

The State performs the enrollment function and does not allow the PIHP to enroll Medicaid eligible persons nor are there any voluntary enrollments in the Iowa Plan. The contract with the Iowa Plan Contractor prohibits marketing on the part of the Contactor.

2. ___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. ___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. ___ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. **Non-English Languages**

Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as
Spanish: (check any that apply):

1. The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. The languages spoken by approximately 4 percent or more of the potential enrollee/ enrollee population.

3. Other (please explain):

Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

Response

Oral translation services are available to enrollees who call the PIHP’s toll free line for enrollees. The PIHP uses Pacific Interpreters services to facilitate communication with non-English speaking persons. Over one hundred language interpreters are available who speak with both the enrollee and the staff of the PIHP. The toll free number is provided to enrollees in the initial mailing to them at the time of enrollment and the annual mailing after that.

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Response

Informational material explaining the Iowa Plan program is mailed to all new enrollees upon the state's notification to the PHIP of enrollment. If the Enrollee's preferred language is known via the eligibility file sent to the PIHP from the state, and if the preferred language is Spanish, the enrollment information is sent in Spanish. All other Enrollees are sent the enrollment information (a letter and handbook) in English that includes notification (in Spanish and English) of the availability of the Spanish version upon request. Additionally the PIHP issues an annual newsletter to all enrollees to provide information on mental health and substance abuse services.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify) _____

X There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- (i) the State
- (ii) State contractor (please specify): _____
- (ii) X the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

___ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

X The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

Response

The State seeks a waiver from the requirement to have more than one Managed Care choice for an enrollee, Section 1902(a)(4), 42 CFR 438.52(a). In addition the State Seeks a waiver of disenrollment, section 1902(a)(4), 42 CFR 438.56. Enrollees of the Iowa Plan are required to receive all Medicaid-funded covered, required, and optional mental health and substance abuse service through the Iowa Plan Contractor except certain services paid by IME. The IME notes that it added Remedial Services (renamed BHIS) effective July 1, 2011 and Psychiatric Medical Institutions for Children effective July 1, 2012. The enrollee shall use only participating providers of services unless the Contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Enrollees will have a choice of providers which offer the appropriate service at the needed level of care. There is no FFS alternative system in place.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.** Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Response

Within 10 days of notification to the Contractor, the Contractor mails out an explanation of the services and list of providers to the enrollee. Also, the Contractor has an enrollee phone line that an enrollee may call to inquire about services. The contractor has the 'magellanofiowa.com' web site which includes many types of educational materials that may benefit the enrollee, provider search functions, newsletters, and the enrollee handbook. The Contractor has an intensive care management component that seeks out special populations and offers more intensive services and treatment planning to these persons

b. **Administration of Enrollment Process.**

State staff conducts the enrollment process.

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: _____

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

- This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

Response

The State expects to add the coverage of the psychiatric medical institutes for children (PMIC) effective July 1, 2012.

- If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.
- i. Potential enrollees will have ___ days/month(s) to choose a plan.
- ii. Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- The State **automatically enrolls** beneficiaries
- on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

- The State provides **guaranteed eligibility** of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

- The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

- The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

- ___ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
- i. ___ Enrollee submits request to State.
 - ii. ___ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
 - iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

X The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

- ___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ___ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

- ___ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

___ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

- i. ___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
- ii. ___ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. ___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

- iv.____ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs.**

a. **Direct access to fair hearing.**

- The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
- The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

- The State’s timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days (between 20 and 90).
- The State’s timeframe within which an enrollee must file a **grievance** is __ days. NO LIMIT

c. Special Needs

- The State has special processes in place for persons with special needs. Please describe.

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee’s freedom to make a request for a fair hearing or a PCCM or PAHP enrollee’s direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

The State has a grievance procedure for its __ PCCM and/or __ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

- The grievance procedures is operated by:
 - the State
 - the State’s contractor. Please identify: _____
 - the PCCM
 - the PAHP.

Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

- ___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

- ___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

- ___ Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process_____

- ___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

- ___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

- ___ Other (please explain):

F. Program Integrity

1. Assurances.

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

| | |
|----------------|---|
| Program Impact | (Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems) |
| Access | (Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care) |
| Quality | (Coverage and Authorization, Provider Selection, Quality of Care) |

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

| MONITORING PLAN | | | | | | | | | | | | |
|--|------------------------------|-----------|------------------|-------------------|------------------------------|----------------------|---------------|-------------------------|-------------------------|------------------------|--------------------|-----------------|
| Monitoring Activity | Evaluation of Program Impact | | | | | Evaluation of Access | | | Evaluation of Quality | | | |
| | Choice NA | Marketing | Enroll Disenroll | Program Integrity | Information to Beneficiaries | Grievance | Timely Access | PCP/Specialist Capacity | Coordination/Continuity | Coverage/Authorization | Provider Selection | Quality of Care |
| Accreditation for Non-duplication | | | | | | | | | | | | |
| Accreditation for Participation | | | | X | | | | | | | | X |
| Consumer Self-Report data | | | | | X | | X | | X | | | X |
| Data Analysis (non-claims) | | | X | X | X | X | X | X | X | X | X | X |
| Enrollee Hotlines | | | | | X | X | X | | X | | | X |
| Focused Studies | | | | | | | X | | X | X | | X |
| Geographic mapping | | | | | | | X | X | | | | |
| Independent Assessment | | | | | | | | | | | | |
| Measure any Disparities by Racial or Ethnic Groups | | | | | | | X | | X | | | |
| Network Adequacy Assurance by Plan | | | | | | | X | X | X | X | X | X |
| Ombudsman | | | | | | | | | | | | |
| On-Site Review | | | | | X | X | X | | X | X | | X |
| Performance Improvement Projects | | | | | | | X | | X | | | X |
| Performance Measures | | | | | X | X | X | | X | X | | X |
| Periodic Comparison of # of Providers | | | | | | | | | | | | |
| Profile Utilization by Provider Caseload | | | | | | | | | X | X | | X |
| Provider Self-Report Data | | | | | | | X | | X | X | | X |
| Test 24/7 PCP Availability | | | | | | | | | | | | |
| Utilization Review | | | | X | | X | X | | X | X | | X |
| Other: (describe) | | | | | | | | | | | | |

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

- a. Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

- b. Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The contractor is required to become accredited as a prerequisite to winning the competitive procurement and is required to maintain accreditation. The on-site visit is scheduled for this fall.
- **Frequency of use:** The accreditation must be obtained with 2 years of contract award.
- **How it yields information about the area(s) being monitored:** Magellan must provide proof of accreditation to

the State. State uses the accreditation as a proxy measure for quality of care.

Accreditation for Participation is used to monitor:

- Program Integrity
- Quality of Care

c. X

Consumer Self-Report data

 CAHPS (please identify which one(s))

 X State-developed survey

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:**
 - a) Monitoring Performance Indicator #1: Consumer Satisfaction Survey
Goal: Consumer satisfaction surveys shall be conducted at least two times over contract period.
 - b) Monitoring Performance Indicator #2: Consumer Satisfaction Survey (Also QI Workplan: Member Satisfaction)
Goal: $\geq 85\%$ of respondents will indicate some degree of satisfaction with services provided by the Iowa Plan.
The survey instrument was developed by Magellan with input from the Consumer/Family Member/Advocate Roundtable and the Quality Improvement (QI) Committee. The survey instrument was approved by the State. Survey results are reported and reviewed by the QI Committee, which includes consumer and family representatives as well as the State. The survey instrument and results are included in Magellan's QI Workplan, QI Quarterly Reports, and QI Annual Report (which serves as the annual Iowa Plan quality evaluation) and are reviewed as part of the External Quality Review process.
- **Frequency of use:** The Client Satisfaction Survey process is done twice each contract year. The sample for each survey is drawn from Iowa Plan Medicaid enrollees who received a covered service in the previous six months and who have not been surveyed before.
- **How it yields information about the area(s) being monitored:** Client Satisfaction Survey information is used to monitor:
 - Information to Beneficiaries
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

Survey responses are sorted by child/adolescent and adult enrollees. Responses are analyzed to understand basic information regarding access, availability, and provider coordination and to measure member satisfaction with care. Information is used to identify issues for follow-up through quality improvement processes and to improve consumer information for member use.

- Disenrollment survey
- X Consumer/beneficiary focus groups

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan holds Consumer/Family Advisory Committee and Children's Mental Health Stakeholders Roundtable meetings to address Iowa Plan issues from the consumer/family/advocate perspectives. Effective July 1, 2004, the State required Magellan to establish a Consumer/Family Advisory Committee which replaced the existing Consumer/Family Member/Advocate Roundtable. Magellan recommended Advisory Committee members for approval by the State. The Consumer/Family Advisory Committee is an advisory body to Magellan and is responsible for:
 - review of Magellan's annual Iowa Plan Quality Assessment and Performance Improvement (QA) Plan
 - input on annual Iowa Plan Quality Improvement goals
 - review of Magellan's year-end performance relative to the QA Plan, including review of Performance Indicators
 - feedback on operational issues experienced by consumers, family members, and/or providers
 - input on potential areas for service development or service improvement
- **Frequency of use:** The Consumer/Family Advisory Committee and the Children's Mental Health Stakeholders Roundtable meet on a quarterly basis, at minimum.
- **How it yields information about the area(s) being monitored:** Input from consumer focus groups is used to monitor:
 - Information to Beneficiaries
 - Timely Access
 - Coordination/Continuity
 - Quality of CareFocus groups foster communication and improvement of plan operations by providing stakeholders with plan information and soliciting feedback from impacted stakeholders. The

information gathered is integrated into quality improvement processes, as indicated. Focus groups provide information regarding the effectiveness of the Iowa Plan and assist in the identification of strengths and weaknesses. Information is obtained from members both in terms of questions or topic areas that are presented to them and in terms of the questions or concerns members may raise separate from a meeting's agenda. Advisory Committee and Roundtable members receive responses to any questions or concerns they raise.

d. X Data Analysis (non-claims)

Magellan initiates Performance Measures to better understand critical issues that are not meeting established goals or that have the potential for high impact on enrollees. The Performance Measure process includes analysis of barriers, statistical analysis, description of interventions, and associated reporting. Analysis of barriers and interventions related to Performance Measures are documented in QI Committee minutes.

- Denials of referral requests
- Disenrollment requests by enrollee
 - From plan
 - From PCP within plan
- Grievances and appeals data

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Grievance and Appeal information is included in monthly and annual QI reporting and is reviewed at least quarterly by the QI Committee. Specific performance measures address Grievances and Appeals including:
 - a) Penalty Performance Indicator #9: Appeals Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)
Goal: $\geq 95\%$ of appeals resolved within 14 calendar days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial 14 day period.
 - b) Penalty Performance Indicator #10: Expedited Appeal Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)
Goal: 100% of expedited appeals resolved within 72 hours; $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the 24-hour period.

- c) Penalty Performance Indicator #11: Grievance Reviews (Also QI Workplan: Percent of Grievances that met Turn-around Time Standard)
Goal: $\geq 95\%$ of grievances resolved within 14 calendar days; 100% resolved within 60 calendar days.
- d) QI Workplan: Grievance Responsiveness - Grievances per 1000
Goal: $\leq .5/1000$ members
- e) QI Workplan: Grievance Responsiveness - Mean time to Grievance Resolution
- f) QI Workplan: Appeals Responsiveness - Percent of Appeals that led to Overturn of UM Decision
- g) QI Workplan: Member Requests Change of Provider
- **Frequency of use:** Data are gathered and reported monthly and quarterly with quarterly review by the QI Committee, at a minimum.
- **How it yields information about the area(s) being monitored:** Grievance and Appeal data are used to monitor:
 - Program Integrity
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Provider Selection
 - Quality of Care

Grievance and Appeal data are integrated into QI processes as part of the overall QI Workplan. The data are analyzed to identify trends and sentinel and adverse events. The findings are reported to the QI Committee and to the State. QI Committee members discuss findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects

 PCP termination rates and reasons
 X Other (please describe)

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Numerous Iowa Plan requirements are monitored through analysis of non-claims data.
Examples include:
 - a) Incentive Performance Indicator #1: Readmission Rates
Goal: 30-day readmission rate at 14% or less.

- b) Penalty Performance Indicator #1: Consumer Involvement
Goal: New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name is provided to Magellan; 95% in 10 working days, 100% in 15 working days
- c) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
- d) Penalty Performance Indicator #5: Quality of Care Goal: Magellan shall arrange or participate in at least 20 Joint Treatment Planning conferences per month and 450 per year.
- e) Penalty Performance Indicator #7: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.
- f) QI Workplan: Membership - Total of all Medicaid Enrolled Clients
- g) QI Workplan: Critical Incident and QI Occurrence Reporting - Total Number of Critical Incidents Reported
- h) QI Workplan: Clinical Practice Guidelines Educate providers on Clinical Practice Guidelines and encourage compliance.
- **Frequency of use:** While ad hoc reporting and analysis can be done as indicated, most analysis is linked to data gathered on a monthly basis for the QI Workplan and Iowa Plan Performance Indicators and is reported monthly and quarterly to the State.
- **How it yields information about the area(s) being monitored:** Non-claims data are used to monitor:
 - Enrollment/Disenrollment
 - Information to Beneficiaries
 - Timely Access
 - Specialist Capacity
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

Information is reviewed and analyzed as part of Magellan's QI processes to identify trends and sentinel or adverse events. The data and findings are reported to Magellan's QI Committee and the State. Committee members discuss findings to identify opportunities for improvement.

e. X Enrollee Hotlines operated by State

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan has staff on-site in their Iowa office available by 800 phone number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls range from non-urgent requests for referral to behavioral health crises. The 800 number (1-800-317-3738) is published in the Iowa Plan Client Handbook and associated materials. The Client Handbook is included in the documents sent by Magellan to new enrollees. This information is also part of the annual notification to all Iowa Plan enrollees and is available whenever requested.
- **Frequency of use:** The 800 number is available 24 hours a day, every day.
- **How it yields information about the area(s) being monitored:** The client 800 # is used to monitor:
 - Information to Beneficiaries
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

The data are used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. The information obtained from the enrollees is integrated into Magellan's QI process and Workplan and is reported to the QI Committee and the State. Committee members discuss the findings to identify opportunities for improvement.

f. X Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Focused Studies are conducted as indicated to monitor and intervene as necessary with operational or quality issues or trends. Generally, in minutes and other documentation, Magellan defines Focused Studies as Performance Measures. These are separate

and distinct from Performance Indicators as described in the Performance Measures sections of the waiver application.

- **Frequency of use:** Focused Studies/Performance Measures are initiated as indicated by data or as identified or recommended by Magellan staff, the State, QI Committee members, or other stakeholders. Such studies generally run for two - three months. If analysis of a Focused Study/Performance Measure identifies significant improvement opportunities or suggests formal interventions are needed, a Performance Improvement Project may be initiated.
- **How it yields information about the area(s) being monitored:** Focused Studies/Performance Measures are used to monitor:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

The data collected are used to: 1) develop a quantitative understanding of the health care or service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and/or 3) identify processes and areas for detailed study through on-going Focused Studies/Performance Measures or Performance Improvement Projects. Analysis is part of each month's QI Committee and is reported to the State. Committee members discuss findings to identify opportunities for improvement. Information and analysis aids in the assessment of the effectiveness of quality improvement processes.

g. X Geographic mapping of provider network

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:**
 - a) Network Status Report
Geographic mapping is done through Geo Access reporting which shows distribution of provider types across the state. Information is submitted to the State in Network Status reports. Reports have the capability of mapping provider locations in Iowa. Examples of provider types shown through Geo Access reporting include psychiatrists, psychologists, social workers, and group practices.
 - b) Monitoring Performance Indicator #4: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.

- c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 30 minutes;
Rural: Inpatient - 45 minutes, Outpatient - 30 minutes.
- d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
- **Frequency of use:** Network Status reports are submitted as part of the QI Quarterly Report package. Performance Indicators and QI Workplan measures are discussed monthly by the QI Committee and are submitted as part of the QI Quarterly Report.
- **How it yields information about the area(s) being monitored:**
Provider geographic information is used to monitor:
 - Timely Access
 - PCP/Specialist Capacity
 Provider geographic information is analyzed for compliance with access and capacity requirements. The analysis is part of the QI Workplan and is reported to Magellan's QI Committee and to the State. Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, Magellan conducts corrective action until compliance is met.

h. NA Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

i. X Measurement of any disparities by racial or ethnic groups

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan initiated a Performance Improvement Project during the 2005-06 contract year to support development of culturally-specific outpatient substance abuse services in Des Moines. The PIP was based on data related to access by different racial/ethnic groups that suggested black/African American enrollees had lower rates of use of outpatient substance abuse services as compared to more intensive services. The PIP was revised into a Performance Measure in 2008 and development continues to be consistent with focused discussion by the Iowa Plan Advisory Committee. The committee is currently looking at differences between utilization and eligibility according to identified ethnic groups. The data is being analyzed across services, diagnoses, and by geographic area. Further analysis of the data and discussion by the committee is expected to result in identified interventions to attempt to correct any disparities that exist.

- **Frequency of use:** The Performance Measure will be reviewed and discussed monthly by the QI Committee and included in the QI Quarterly Report.
- **How it yields information about the area(s) being monitored:**
Measurement of Disparity will monitor:
 - Timely Access
 - Coordination/Continuity
 The PM will continue to provide information on general enrollee use of services before and after initiation of culturally specific services as a service option in the Des Moines area.

j. X

Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

 X **Network Reports**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.
 - a) Network Status Report
Information is submitted to the State in Network Status reports. Examples of provider types reviewed include psychiatrists, psychologists, social workers, and group practices.
 - b) Monitoring Performance Indicator #4: Compliance with Access Standards
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
 - c) Monitoring Performance Indicator #5: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 30 minutes; Rural: Inpatient - 45 minutes, Outpatient – 30 minutes
 - d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
 - e) QI Workplan: Network Adequacy - Density

The number of providers per 1000 members.

- **Frequency of use:** Documentation was submitted at the time of contracting and is submitted any time there is a significant change that would affect adequate capacity and services or at enrollment of a new population. Network Status and Performance Indicator reports are submitted quarterly as part of the QI Quarterly Report package. QI Workplan reports are submitted monthly as part of the materials for the QI Committee and are included in the QI Quarterly Report. Performance Indicator and QI Workplan reports are also included in the QI Annual Report.
- **How it yields information about the area(s) being monitored:** Network reports provide information on:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

Data are used to: 1) develop a quantitative understanding of the service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. Analysis results become part of the QI Workplan and are reported to Magellan's QI Committee and the State. Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. If indicated, Magellan implements corrective action through QI processes, including focused studies/Performance Measures

X Other - Credentialing

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The credentialing/contracting process includes consideration of provider qualifications for the Iowa Plan network. Credentialing activities are under the purview of Magellan's Professional Provider Review Committee, a subcommittee to the QI Committee.
 - a) Penalty Performance Indicator #12: Network Management (Also QI Workplan: Timeliness of Credentialing and Re-Credentialing)
Goal: Credentialing of Iowa Plan providers shall be completed as follows: 60% in 30 days, 100% in 90 days.
- **Frequency of use:** Credentialing is one step in a prospective provider's contracting process with Magellan for the Iowa Plan. Re-credentialing is done with all existing providers at least every three years. Credentialing review may also be done based on provider-specific considerations.

- **How it yields information about the area(s) being monitored:** Credentialing monitors information related to :
 - Timely Access
 - Coverage/Authorization
 - Provider Selection
 - PCP/Specialist Capacity
 - Quality of Care

Information obtained from the credentialing process is part of the QI Workplan and is discussed at least quarterly by the QI Committee. The State monitors Magellan's credentialing process through the QI Workplan and Performance Indicators and through the QI Quarterly and Annual reports.

X Clinical On-Site Review

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Clinical on-site review is conducted with providers to monitor the appropriateness and quality of clinical services delivered to members, compliance with Iowa Plan requirements, and associated documentation. Magellan has three mental health QI Clinical Reviewers and one substance abuse QI Clinical Reviewer, all credentialed clinicians, who visit providers across the state. One mental health reviewer and the substance abuse reviewer are located in Magellan's Des Moines office. One mental health reviewer is located in her home office in eastern Iowa, and the third mental health reviewer is located in Magellan's Sioux City office in western Iowa. The reviewers use specific forms and processes to work with providers. Providers receive copies of their site visit reports.

Certain activities related to on-site review are documented as follows:

- a) Incentive Performance Indicator #7: Quality of Care
Goal: $\geq 94\%$ of all discharge plans written for enrollees discharged from mental health inpatient shall be implemented; with ≥ 240 records reviewed.
- b) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
- c) Penalty Performance Indicator #6: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90 % of enrollees discharged from substance abuse residential treatment.
- d) Monitoring Performance Indicator #4: Compliance with Access Standards (Also QI Workplan: Accessibility of

Behavioral Healthcare Services - Wait Times for Initial Appointments)

Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.

- e) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
- f) QI Workplan: Clinical Practice Guidelines Educate providers on Clinical Practice Guidelines and encourage compliance.
- g) QI Workplan: Retrospective Treatment Record Reviews - Percent Compliance with Tool
- **Frequency of use:** Clinical on-site review is conducted annually, at a minimum. Additional focused reviews may be conducted as part of follow-up to a corrective action plan requirement, based on the recommendation of the Professional Provider Review Committee, or because of quality or contractual indicators.
- **How it yields information about the area(s) being monitored:** Clinical on-site review information is used to monitor:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

As a result of on-site monitoring, Magellan offers education and technical assistance to providers. Magellan must offer orientation and on-going training to network providers at least two times per year. Technical assistance is done with specific providers or provider groups based on their request or an identified need through an on-site review or other monitoring.

k. _____ Ombudsman

l. X On-site review

 X External Quality Review

- **Applicable program:** PIHP
- **Personnel responsible:** External entity identified by State, currently the Iowa Foundation for Medical Care.
- **Detailed description:** External Quality Review is a process by which an External Quality Review Organization, through a

specific agreement with the State, reviews and evaluates Magellan policies and processes implemented for the Iowa Plan. External Quality Reviews include extensive review of Magellan documentation and interviews with Magellan staff. Interviews with Iowa Plan stakeholders and confirmation of data may also be conducted.

- **Frequency of use:** External Quality Review is done annually.
- **How it yields information about the area(s) being monitored:** External Quality Review provides monitoring information related to:
 - Information to Beneficiaries
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

The External Quality Review allows a review of automated systems and communication with the Contractor staff that perform each of the above processes. It also obtains additional information that was not provided as part of State monitoring through conference calls, meetings, documentation requests, or quarterly reports. Data from all sources are analyzed for compliance. If indicated, Magellan is required to implement corrective action.

m. X Performance Improvement projects [**Required** for MCO/PIHP]
 X Clinical

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** As stated in the Iowa Medicaid Managed Care Quality Assurance System document, the Contractor must conduct Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
- **Frequency of use:** Two Performance Improvement Projects must be active at any given time. The status of each project is reported to the State each quarter.
- **How it yields information about the area(s) being monitored:** Performance Improvement Projects provide monitoring information related to:
 - Timely Access

- Coordination/Continuity
- Quality of Care

PIPs are chosen based upon the information obtained through other monitoring processes. The QI Workplan provides information about the Performance Improvement Projects. PIPs must involve the following:

1. Measurement of performance using objective quality indicators.
2. Implementation of system interventions to achieve improvement in quality.
3. Evaluation of the effectiveness of the interventions.
4. Planning and initiation of activities for increasing or sustaining improvement.

___ Non-clinical

n. X

Performance measures [**Required** for MCO/PIHP]

- Process
- Health status/outcomes
- Access/availability of care
- Use of services/utilization
- Health plan stability/financial/cost of care
- Health plan/provider characteristics
- Beneficiary characteristics

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The State has established a comprehensive listing of performance measure areas, entitled Performance Indicators, for Magellan's implementation of the Iowa Plan. In addition to Performance Indicators, cost of care data are summarized for each Plan capitation cell as part of the Magellan Iowa Plan reporting package to the State. Annual audits address financial considerations.
- **Frequency of use:** Performance Indicators are included on the QI Workplan reviewed monthly in the QI Committee. A year-to-date Performance Indicators report is submitted as part of the QI Quarterly and Annual reports. Other data reporting is done each month. Audits are done each year.
- **How it yields information about the area(s) being monitored:** Performance measures provide information related to:
 - Information to Beneficiaries
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization

- Quality of Care

Performance Indicator data are reported monthly in the QI Workplan and are reviewed each month by the QI Committee. A Performance Indicator report is also included in the QI Quarterly and Annual reports. The indicators aid in the identification of opportunities for quality improvement. In addition, this information aids in the assessment of initiative effectiveness.

- o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver
- p. X Profile utilization by provider caseload (looking for outliers)

X **Provider Profiling**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Provider Profiling documents provider-specific performance on key elements of the Iowa Plan and aggregates such data for comparison review and to identify outliers.
- **Frequency of use:** Provider Profiling is generated and distributed each quarter.
- **How it yields information about the area(s) being monitored:** Provider Profiling offers information for monitoring:
 - Coordination/Continuity
 - Coverage/AuthorizationEach provider can download their specific profile, the aggregate provider profile aggregate provider profile of like providers via the magellanofiowa.com web site. The aggregate report is used by the State and Magellan to identify of opportunities for quality improvement or technical assistance.

X **Provider Medication Monitoring**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan; Drug Utilization Review Commission
- **Detailed description:** Magellan works with the Drug Utilization Review Commission to understand and monitor prescribing of psychotropic medications, including monitoring for potential changes in overall utilization by those enrolled in the Iowa Plan.
 - a) Monitoring Performance Indicator #16: Psychotropic Medication Screening

Goal: Magellan shall identify medication utilization that deviates from current clinical practice guidelines; specifically, the contractor shall report quarterly and year-to-date instances of three or more drugs in the same class being prescribed per enrollee.

- **Frequency of use:** Monitoring activities are reported in the QI Quarterly Report.
- **How it yields information about the area(s) being monitored:** Provider medication monitoring provides information related to:
 - Coordination/Continuity
 - Quality of Care

Performance Indicator data are reported monthly in the QI Workplan and are reviewed each month by the QI Committee. A Performance Indicator report is also included in the QI Quarterly Report and the QI Annual Report. Analysis is part of the QI Workplan and is reported to Magellan's QI Committee and to the State. Committee members discuss the findings to identify opportunities for improvement. Magellan initiates QI processes as indicated.

q. X

Provider Self-report data

 X Survey of providers

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Administration no less than annually of a provider satisfaction survey.
 - a) Monitoring Performance Indicator #8: Provider Satisfaction Survey (Also QI Workplan: Provider Satisfaction)

Goal: Magellan will conduct an annual provider survey in which $\geq 80\%$ of network providers responding indicate satisfaction.
- **Frequency of use:** The Provider Satisfaction Survey is distributed each year.
- **How it yields information about the area(s) being monitored:**
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

Results are reviewed in the QI Committee and are included in QI Quarterly and Annual reports. The survey process and results are also reviewed through the annual External Quality

Review process. If areas for improvement are noted, Magellan incorporates identified issues into QI processes.

X Focus groups

- **Applicable program:** PIHP
 - **Personnel responsible:** State; Contractor/Magellan
 - **Detailed description:** There are three distinct structured methods by which providers give input to the Iowa Plan.
 - 1) The Iowa Plan Advisory Committee is an advisory body to the State, staffed by Magellan. The Iowa Plan Advisory Committee advises the State on strategic and operational issues regarding the Iowa Plan and provides for ongoing public input.
 - 2) The Clinical Advisory Committee is an advisory body to Magellan related to Iowa Plan clinical issues.
 - 3) Magellan holds up to four Provider Roundtables each year that provide continuing education opportunities to providers and are a forum for input into the Iowa Plan.
 - **Frequency of use:** The Iowa Plan Advisory Committee, the Clinical Advisory Committee, and Provider Roundtables generally meet each quarter.
 - **How it yields information about the area(s) being monitored:** Input from provider focus groups is used to monitor:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care
- Iowa Plan Advisory Committee responsibilities include:
- review of the Magellan annual Iowa Plan Quality Assessment and Performance Improvement Plan (QA Plan)
 - input on annual Iowa Plan Quality Improvement Goals
 - review of Magellan's year-end performance relative to the QA Plan, including review of Performance Indicators
 - feedback on operational issues experienced by consumers, family members, and/or providers
 - input on potential areas for service development or service improvement
- Clinical Advisory Committee responsibilities include:
- annual review of Utilization Management Guidelines
 - review of utilization management and care management programs and protocols

- review and recommendations on level of functioning scales and associated activities
- input on quality assurance and performance improvement projects

Provider Roundtables are a forum for input into the Iowa Plan on all aspects of plan operation.

r. _____ Test 24 hours/7 days a week PCP availability

s. X Utilization review (e.g. ER, non-authorized specialist requests)

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Utilization review is the process by which Magellan monitors all clinical activities and associated data, including authorization/non-authorization of services and encounter data.
 - a) Incentive Performance Indicator #1: Readmission Rate (Also QI Workplan: 30-Day Readmission)
Goal: $\leq 14\%$ of enrollees discharged from mental health inpatient readmit to inpatient within 30 days of discharge
 - b) Incentive Performance Indicator #2: Community Tenure
Goal: The average time between mental health hospitalizations epr contract period shall not fall below 94 days for Iowa Plan Enrollees.
 - c) Incentive Performance Indicator #3: Service Array
Goal: At least 18% of mental health service expenditures will be used in the provision of integrated services and supports, consumer-run programs and services delivered in the home.
 - d) Incentive Performance Indicator #4: Quality of Care (Also QI Workplan: 7-Day Ambulatory Follow-up)
Goal: $\geq 90\%$ of persons discharged from mental health inpatient will receive other treatment services in seven days.
 - e) Incentive Performance Indicator #6: Quality of Care
Goal: $>60\%$ of enrollees discharged from ASAM Levels III.5 and III.3 receive a follow-up substance abuse service in 14 days.
 - f) Penalty Performance Indicator #4: Quality of Care
Goal: $\geq 95\%$ of enrollees who received services in an emergency room and for whom inpatient was requested but not authorized shall have a follow-up contact in three business days of the date Magellan is notified of the ER service.
 - g) Monitoring Performance Indicator #18 Dual Diagnosis
Goal: Magellan shall increase the percent of dually diagnosed Enrollees discharged from inpatient substance abuse and mental health treatment settings such that at least 75% of discharged

Enrollees receive either a substance abuse or mental health services within 7 days of discharge.

h) Monitoring Indicators #14 Adults) and #8 (Children): Outcome Measures:

Goal: At least 50% of adults (children) receiving Iowa Plan outpatient services report improvement in emotional health as reported by comparison of initial and most recent assessment using the Consumer Health Inventory (CHI) or CHI for children.

i) QI Workplan: Clinical Non-authorizations per 1,000

j) QI Workplan: Clinical Authorizations per 1,000

- **Frequency of use:** Data related to utilization review are reported in the QI Quarterly Report and are reviewed by the QI Committee.
- **How it yields information about the area(s) being monitored:**
Utilization review data can be used to monitor:
 - Program Integrity
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

The data are used to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. This information is primarily used for provider and enrollee monitoring and is part of the QI Workplan. Analysis is reported to Magellan's QI Committee and to the State. Committee members discuss findings to identify opportunities for improvement. If areas for improvement are noted, Magellan works with the specific provider noted or incorporates the identified aspects into QI processes.

t. _____ Other: (please describe)

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

Yes

___ No. Please explain:
 Summary of results:
 Problems identified:
 Corrective action (plan/provider level)
 Program change (system-wide level)

| MONITORING RESULTS | | | | | | | | | | | | |
|--|------------------------------|-----------|------------------|---------|----------------|----------------------|---------------|----------------|----------------------------|------------------------|----------|-----------------|
| Monitoring Activity | Evaluation of Program Impact | | | | | Evaluation of Access | | | Evaluation of Quality | | | |
| | Choice NA | Marketing | Enroll/Disenroll | Program | Information to | Grievance | Timely Access | PCP/Specialist | Coordination/Authorization | Coverage/Authorization | Provider | Quality of Care |
| Accreditation for Non-duplication | | | | | | | | | | | | |
| Accreditation for Participation | | | | X | | | | | | | | X |
| Consumer Self-Report data | | | | | X | | X | X | | | | X |
| Data Analysis (non-claims) | | | X | X | X | X | X | X | X | X | X | X |
| Enrollee Hotlines | | | | | X | X | X | | X | | | X |
| Focused Studies | | | | | | | X | | X | X | | X |
| Geographic mapping | | | | | | | X | X | | | | |
| Independent Assessment | | | | | | | | | | | | |
| Measure any Disparities by Racial or Ethnic Groups | | | | | | | X | | X | | | |
| Network Adequacy Assurance by Plan | | | | | | | X | X | X | X | X | X |
| Ombudsman | | | | | | | | | | | | |
| On-Site Review | | | | | X | X | X | | X | X | | X |
| Performance Improvement Projects | | | | | | | X | | X | | | X |
| Performance Measures | | | | | X | X | X | | X | X | | X |
| Periodic Comparison of # of Providers | | | | | | | | | | | | |
| Profile Utilization by Provider Caseload | | | | | | | | | X | X | | X |
| Provider Self-Report Data | | | | | | | X | | X | X | | X |
| Test 24/7 PCP Availability | | | | | | | | | | | | |
| Utilization Review | | | | | | X | X | | X | X | | X |
| Other: (describe) | | | | | | | | | | | | |

b. X **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

NCQA

JCAHO

AAAHC

Other (please describe)

- **Strategy:** Magellan must be accredited.

- **Confirmation:** Yes

- **Summary of results:**

Magellan's Iowa office was accredited by the American Accreditation Health Care Commission/URAC in November 1997. The contractor has maintained accreditation since that time, with the most recent review resulting in full accreditation effective through June 1, 2013.

- **Problems identified:** URAC made no formal recommendations for follow-up in Magellan's last three accreditation processes. The following opportunities for improvement were identified in the 2010 re-accreditation summary report:
 - Review the security of fax machines during the evening (they should be shut off after staff leave, as cleaning staff and others are still present in the buildings. This recommendation was implemented immediately.
 - A couple of desks were noted to have locks that were not working, they recommended that locks be fixed which has been done.
- **Corrective action** (plan/provider level): No formal corrective action required.
- **Program change** (system-wide level): Magellan is required as part of the RFP process in 2009 to obtain accreditation through NCQA by the Fall of 2011.

c. X **Consumer Self-Report data**

State-Developed Survey

- **Strategy:** Magellan distributes consumer satisfaction surveys twice each year.

- **Confirmation:** Yes

- **Summary of results:**

a) Monitoring Performance Indicator #2: Consumer Satisfaction Survey

Goal: Consumer satisfaction surveys shall be conducted at least two times over contract period.

Magellan Client Satisfaction Surveys were distributed in May 2009, November 2009, May 2010, and November 2010.

b) Monitoring Performance Indicator #3: Consumer Satisfaction Survey (Also QI Workplan: Member Satisfaction)

Goal: $\geq 85\%$ of respondents will indicate some degree of satisfaction with services provided by the Iowa Plan.

Magellan Performance (Quarterly reports):

May 2009 – 88.1% Adult, 89.1% Child/Adolescent

November 2009 - 89.9% Adult, 92.1% Child/Adolescent

May 2010 – 89.6% Adult, 84.2% Child/Adolescent

November 2010 – 89.4% Adult, 86.0% Child/Adolescent

- **Problems identified:** the QI Committee have reviewed all Consumer Satisfaction Survey results. In May 2010, the results for child/adolescents was lower than the 85%. The members reviewed all questions and decided to monitor until the next survey which again exceeded the target of 85%. On an ongoing basis, evening and weekend appointments, cultural preferences for services, and access.
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X **Consumer/Beneficiary Focus Groups**

- **Strategy:** Magellan holds regularly scheduled meetings for consumer/beneficiary input into the Iowa Plan.
- **Confirmation:** **X** Yes
- **Summary of results:** Magellan held quarterly Consumer/Family Advisory Committee meetings and Children's Mental Health Stakeholders Roundtable meetings during the 2008-2010 Iowa Plan contract years. The meetings addressed Iowa Plan issues from consumer, family member, and advocate perspectives. Agenda items have included:
 - overview of the Iowa Plan
 - roles and responsibilities of the Advisory Committee, including review of Magellan's annual Iowa Plan Quality Assessment and Performance Improvement Plan; input on annual Iowa Plan QI Goals; review of Magellan's year-end QA Plan and Performance Indicators performance; feedback on operational issues experienced by consumers, family members, and/or providers; and input on potential areas for service development or service improvement
 - updates on Iowa Plan activities
 - updates on the addition of the 65+ population and asked for feedback and input into making the transition a success

- updates by attendees
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): Because of the success of consumer and beneficiary focus groups, Magellan established a stakeholder group specifically for the 65+ population. Magellan SeniorConnect staff, conducted outreach since June 2009 to key stakeholders including the Iowa Coalition on Mental Health and Aging (ICMHA), Area Agencies on Aging, and providers throughout Iowa.

d. X

Data Analysis (non-claims)

X **Grievance and Appeal Data**

- **Strategy:** Magellan analyzes and reports grievance and appeal data.
- **Confirmation:** X Yes
- **Summary of results:** Examples of results, as documented in the August 2009 and the August 2010 QI Annual Reports and monthly Performance Indicator Reports, are as follows:
 - a) **Penalty Performance Indicator #9: Appeals Reviews** (Also QI Workplan: Percent of Appeals which met Time Standard for Review)
 Goal: $\geq 95\%$ of appeals resolved within 14 calendar days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial 14 day period.
 Magellan Performance: 100.0% resolved in 14 calendar days was achieved between July 1, 2008 and December 31, 2009. There was a slight drop to 98.1% between January and December 2010. All periods met the goal of $>95\%$
 - b) **Penalty Performance Indicator #10: Expedited Appeal Reviews** (Also QI Workplan: Percent of Appeals which met Time Standard for Review)
 Goal: $\geq 95\%$ of expedited appeals resolved within three working days (the standard in 2009) or within 72 hours (standard in 2010).
 Magellan Performance: 100% were resolved within the time frame established with no extensions.
 - c) **Penalty Performance Indicator #11: Grievance Reviews** (Also QI Workplan: Percent of Grievances that met Turn-around Time Standard)
 Goal: $\geq 95\%$ of grievances resolved within 14 calendar days; 100% resolved within 90 calendar days.

Magellan Performance (Performance Indicator Reports and in QI Annual Reports): 100.0% resolved in 14 calendar days.

- d) QI Workplan: Grievance Responsiveness - Grievances per 1000

Goal: $\leq .5/1000$ members

Magellan Performance (August 2009 and August 2010 QI Annual Reports): 0.03 and 0.10 grievances per 1000 members respectively.

- e) QI Workplan: Grievance Responsiveness - Mean time to Grievance Resolution

Magellan Performance (August 2009 and August 2010 QI Annual Reports): Monitor Only

3.9 days was the highest number of days for a month period with 1.0 days as the lowest

- f) QI Workplan: Appeals Responsiveness - Percent of Appeals that led to Overturn of UM Decision

Magellan Performance (August 2009 and August 2010 Annual reports): rolling periods for MH 31.3% and 24.1% respectively

- g) QI Workplan: Member Requests Change of Provider

Magellan Performance (QI Annual Reports):

0 requests received

- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X Other - Reporting

- **Strategy:** Magellan analyzes and reports on a large variety of non-claims data.

- **Confirmation:** X Yes

- **Summary of results:** Magellan delivered reports as required for the 2008-09 and 2009-10 Iowa Plan contract years. In general, Performance Indicator thresholds and other contract requirements were met. Examples of results from the Performance Indicator Reports for SFY 2010 and/or from QI WorkPlans:

- a) Incentive Performance Indicator #2: Consumer Involvement

Goal: Magellan shall arrange/participate in 450 Joint Treatment Planning Conferences per contract year.

Magellan Performance: 699 Joint Treatment Planning Conferences were conducted. 100% had consumer involvement.

- b) Penalty Performance Indicator #1: Consumer Involvement

Goal: New enrollee information, including a list of

network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name is provided to Magellan; 95% in 10 working days, 100% in 15 working days

Magellan Performance: 100% in 10 working days.

- c) **Penalty Performance Indicator #2: Quality of Care**
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
Magellan Performance: 96.3%
- d) **Penalty Performance Indicator #7: Quality of Care**
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.
Magellan Performance: 100%
- e) **QI Workplan: Membership - Total of all Medicaid Enrolled Clients**
Magellan Performance (QI Annual Reports and QI Work Plan): Enrollment ranged from a low of 297,691 to a high of 355,921 for the months July 2008 - June 2010.
- f) **QI Workplan: Critical Incident and QI Occurrence Reporting - Total Number of Critical Incidents Reported**
Magellan Performance (2009 QI Annual Report): 914 Critical Incidents
- g) **QI Workplan: Clinical Practice Guidelines**
Educate providers on Clinical Practice Guidelines and encourage compliance.
Magellan Performance (QI Quarterly Reports): Magellan has 13 behavioral health Clinical Practice Guidelines publications that are shared with providers and are available at Magellanof Iowa.com under the Provider Section.
 - **Problems identified:** None.
 - **Corrective action** (plan/provider level): None.
 - **Program change** (system-wide level): Clinical Practice Guidelines are topics for Iowa Plan Provider Roundtables and are reviewed with providers during on-site retrospective reviews.

e. X

Enrollee Hotline Operated by State

- **Strategy:** Magellan's Des Moines office is staffed by behavioral health clinicians 24 hours a day, 365 days a year.
- **Confirmation:** X Yes
- **Summary of results:** Calls related to clinical needs were handled by Magellan care management staff. Referral information was made

available as requested. Grievance calls were responded to by appropriate staff and entered into the grievance process.

- a) QI Workplan: Timeliness of Telephone Access - Average Speed of Answer
Goal: ≤ 30 seconds for Client/Provider Services and < 60 seconds for Clinical Care Teams
Magellan Performance (August 2009 and August 2010 QI Annual Reports): Clinical Care Teams - 10 seconds; Client/Provider Services - 9 seconds
- b) QI Workplan: Call Abandonment - Call Abandonment Rate
Goal: $\leq 5\%$
Magellan Performance (August 2009 and August 2010 QI Annual Reports): Clinical Care Teams – 1.9%; Client/Provider Services - 2.7%

- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

f. **X Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

- **Strategy:** Magellan initiates focused studies through Performance Measures to address operational or quality issues or trends.
- **Confirmation:** **X** Yes
- **Summary of results:** Magellan submits Performance Measures as part of the External Quality Review; following are two submitted for the EQR in 2010. Examples are:

a) Outpatient Penetration

Results: The rate for the measurement year (July 1, 2009 – June 30, 2010) was 15.8%, the same as the penetration rate for the previous year (SFY 2009) and slightly higher than the rate of 15.5% the previous year (SFY 2008). In reviewing the rate, there was no need for concern. This will continue to be tracked as a performance measure for July 1, 2010 – June 30, 2011.

b) Emergency Room Penetration

Results: The rate for the measurement year (SFY' 10) was 19.85 presentations per 1,000 enrollees. This is barely lower than the rate for the previous year (SFY 2009), which was 19.89 presentations per 1,000 enrollees. This measure will continue to be tracked as a performance measure for July 1, 2010 – June 30, 2011.

c) Electronic Claims Submission

Results: The number of claims submitted in January 2009 was 48% and by December 2010, the number had increased to 75%. The goal Magellan is striving to get over 85%. The measure will continue to be tracked.

- **Problems identified:** Each Performance Measure (Focused Study) was initiated based on review of standard report data or from a question raised by the Quality Improvement Committee.
- **Corrective action** (plan/provider level): Continue to measure both Performance Measures
- **Program change** (system-wide level): none

g. X

Geographic Mapping of Provider Network

- **Strategy:** Magellan analyzes and reports geographic information on the Iowa Plan provider network.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Network Status Report
Reports delivered.
 - b) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
Magellan Performance (August 2009 and 2010 QI Annual Reports): 100% for all quarters for all levels of need.
 - c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes;
Rural: Inpatient - 45 miles/minutes, Outpatient - 34 miles/30 minutes
Magellan Performance (August 2009 and 10 QI Annual Reports): 100%
 - d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
Magellan Performance (August 2009 and 10 QI Annual Reports):
Evening - Mental Health 87.8%, Substance Abuse 88%;
Weekend - Mental Health 53.2%, Substance Abuse 44%
- **Problems identified:** Lack of child psychiatry services in rural areas. General lack of psychiatry services in rural areas (many providers are paying psychiatrists to travel long distances to see people).

- **Corrective action** (plan/provider level): Continuation of Iowa Plan Community Reinvestment (Beneficiary Services) project to psychiatric services capacity statewide through the use of telehealth resources/
- **Program change** (system-wide level):
Access to psychiatry services has been increased state-wide by making such resources available through telehealth, including care coordination services. Currently there is a network of telehealth psychiatric services in 54 counties. During calendar year 2010, 1,625 clients utilized services through telehealth.

i. X

Measurement of any disparities by racial or ethnic groups

- **Strategy:** Magellan collected baseline data on provider practices and member perception with the goal to develop interventions and training to mitigate identified gaps in disparities by racial or ethnic groups

Baseline data:

- Provider Survey developed and distributed to assess provided cultural competency. This survey focused on providers' perception of barriers to a culturally competent environment and on what tools and practice providers have in place to promote a culturally welcoming environment
- Member satisfaction Survey data: Two questions on the satisfaction survey address member's perception regarding experiencing a culturally welcoming environment
- **Confirmation:** X Yes
- **Summary of results:**

Provider Survey results:

| Survey Question | 2009 |
|---|-------|
| Q1: We attempt to make consumers of various cultural and ethnic backgrounds feel comfortable in our treatment settings. | 94.0% |
| Q 2: We hire staff who reflect the cultural and ethnic makeup of the population we serve. | 66.3% |
| Q3: We receive ongoing education and training in culturally and linguistically appropriate service delivery. | 75.6% |
| Q4: We provide language assistance services and/or bilingual staff and interpreters during all hours of operation. | 39.0% |
| Q 5: We have written policies/procedures in place addressing cultural competency, sensitivity and awareness. | 72.2% |

Member Satisfaction Survey Results:

| Item | Medicaid Adult | Medicaid Adolescent |
|--|-------------------|---------------------|
| 2009 | % of Satisfaction | |
| Q17: Your provider was sensitive to your cultural background | 79.5% | 83.8% |
| Q18: Our cultural preferences and race/ethnic background were included in planning services I received | 61.3% | 71.4% |

- **Problems identified:**

1. Member satisfaction survey results to questions addressing their sense of providers being sensitive to their cultural needs supported these findings. 79.5% of Adult Medicaid respondent indicated that their provider was sensitive to their cultural background and 61.3% indicated that their cultural preferences and race/ethnic background were included in planning services received. Both scores fell below the adolescent scores of 83.8% and 71.4% respectively.
2. The 2009 Provider survey revealed that 94% of providers responding to the survey attempt to make consumers of various cultural and ethnic backgrounds feel comfortable in their treatment settings. However, the percents in other other survey questions is lower.

- **Corrective action** (plan/provider level): Magellan will initiate a series of training and technical assistance to raise the rates in both surveys. Following are examples of some of the trainings:
 - September 24, 2009: “Cultural Competency in Practice” by Jill Fulitano-Avery, Kathryn Baumann-Reese, and Cyndi Chen from the Iowa Department of Human Rights.
 - October 29, 2009: Guest speaker, Frank LeMere shared his experiences with cultural competency from a Native American perspective.
 - March 24, 2010: Aging and Mental Health: Practitioner Approach to Depression Care Management
 - June 24, 2010: The Culture of the Family: What Every Professional Needs to Know Collaboration
 - July 20, 2010: The Culture of the Family: What Every Professional Needs to Know Roles

- **Program change** (system-wide level): Ongoing training and measurement to increase Consumer Satisfaction.

j. X

Network Adequacy Assurance Submitted by Plan [Required for MCO/PIHP/PAHP]

X Network Reports

- **Strategy:** Magellan submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Network Status Report
Quarterly a Network Status Report is submitted to the State. The Report includes a network summary, a list of all providers by county. For individual practitioners, their county, name, professional level, and address is included in the report.
 - b) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
Magellan Performance (August 2009 and August 2010 QI Annual Reports): 100% for all levels of need.
 - c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes; Rural: Inpatient - 45 miles, Outpatient - 34 miles
Magellan Performance (August 2009 and 2010 QI Annual Reports): 100%
 - d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
Magellan Performance (August 2009 and 10 QI Annual Reports): Evening - Mental Health 87.8%, Substance Abuse 88%;
Weekend - Mental Health 53.2%, Substance Abuse 44%
 - e) QI Workplan: Network Adequacy - Density
The number of providers per 1000 members.

Magellan Performance (August 2009 and 2010 QI Annual Reports): 6.8 providers per 1000 members in both reports

- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X Other - Credentialing

- **Strategy:** Magellan's RNCC (Regional Network Credentialing Committee) ((previously known as the Professional Provider Review Committee (PPRC)) is responsible for provider credentialing decisions for contracting under the Iowa Plan for Behavioral Health. (All network providers are recredentialed at least every three years. Often, particular categories of provider types fall in the same cycle. Therefore, there are years where it appears very few providers of a particular type are recredentialed.)
- **Confirmation:** X Yes
- **Summary of results:** The RNCC reports quarterly to the QI Committee and provides updates in the Quarterly Reports. In calendar year 2009, 624 providers were credentialed or re-credentialed by the Iowa RNCC. These included:
 - 195 Facilities/Agencies/Community Mental Health Centers
 - 189 Licensed Independent Social Workers
 - 53 Psychologists
 - 36 Psychiatrists
 - 6 Physician Assistants
 - 9 ARNPs
 - 136 Other Masters Prepared Therapists (Advanced Registered Nurse Practitioners, Licensed Marriage and Family Therapists, Licensed Mental Health Clinicians, etc.)
- a) Penalty Performance Indicator #12: Network Management (Also QI Workplan: Timeliness of Credentialing and Re-Credentialing)
Goal: Credentialing of Iowa Plan providers shall be completed as follows: 60% in 30 days, 100% in 90 days. Magellan Performance: All targets were met. By quarter the range was from 80% to 100% within 30 days and all quarters were at 100% within 90 days.
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X Clinical On-site Review

- **Strategy:** Clinical on-site review is conducted with providers to monitor the appropriateness and quality of clinical services delivered to members, compliance with Iowa Plan

requirements, and associated documentation. (August 2009 and August 2010 Annual Reports)

- **Confirmation:** X Yes
- **Summary of results:**
 - a) Incentive Performance Indicator #8: Quality of Care
Goal: $\geq 90\%$ ($>94\%$ starting on Jan. 2010) of all discharge plans written for enrollees discharged from mental health inpatient shall be implemented; with ≥ 185 (>240 starting Jan. 2010) records reviewed.
Magellan Performance (Performance Indicator Reports): 98% of the 510 files reviewed in the two-year period
 - b) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
Magellan Performance (Performance Indicator Reports): 97.6%
 - c) Penalty Performance Indicator #7: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.
Magellan Performance (Performance Indicator Reports): 100%
 - d) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
Magellan Performance (August 2009 and August 2010 QI Annual Reports): 100% for all levels of need.
 - e) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
Magellan Performance (August 2009 and 10 QI Annual Reports): Evening - Mental Health 87.8%, Substance Abuse 88%;
Weekend - Mental Health 53.2%, Substance Abuse 44%
 - f) QI Workplan: Clinical Practice Guidelines
Educate providers on Clinical Practice Guidelines and encourage compliance. Guidelines are posted on

Magellan's website and may be distributed to providers directly or be reviewed during a Provider Roundtable. Magellan Performance (August 2009 and August 2010 QI Annual Report):

The following Clinical Practice Guidelines:

- Assessing and Managing the Suicidal Patient
- Assessment and Treatment of Patients with Eating Disorders
- Assessment and Treatment of Patients with Post-Traumatic Stress Disorder and Acute Stress Disorder
- Patients with Attention Deficit/ Hyperactivity Disorder
- Treatment of Patients with Bi-Polar Disorder
- Treatment of Patients with Major Depressive Disorder
- Treatment of Patients with Panic Disorder
- Treatment of Schizophrenia
- Treatment of Substance Use Disorders
- Patients with Obesity

g) QI Workplan: Retrospective Treatment Record Reviews - Percent Compliance with Tool

Goal: 85%

Magellan Performance (August 2009 and August 2010 QI Annual Reports): 94.0% Mental Health, 94.0% Substance Abuse in 2009 and 94% Mental Health and 91% Substance abuse in 2010.

- **Problems identified:** Provider technical assistance need areas included clinical documentation, Iowa Plan policies, and treatment and discharge planning.
- **Corrective action** (plan/provider level): QI Clinical Reviewers provided on-the-spot technical assistance for issues, where appropriate. Providers receive detailed written summary reports within 30 days of their site visit. Reports address strengths and weaknesses and include required corrective action, where indicated, and associated due dates. Network-wide issues identified during clinical on-site review were addressed through standing provider communication mechanisms, including care management calls with Magellan staff and Provider Roundtables.
- **Program change** (system-wide level): None

1. X

On-Site Review

X **External Quality Review**

- **Strategy:** DHS contracts with an External Quality Review Organization for annual review of Magellan and implementation of the Iowa Plan. The 2008-2009 EQR was conducted by the Iowa Foundation for Medical Care on behalf of the State on March 8, 2010. The objective of the evaluation

was to measure the effectiveness of Magellan’s Medicaid managed care program and processes in meeting the requirements of the Balanced Budget Act of 1997 as defined in the federal regulation (CFR 433 and 438). The content of the review included:

1. Validation of Performance Improvement Projects (PIPs) that were underway during the preceding 12 months as required in 42 CFR 438.240 (b)(1).
2. Validation of Performance Measures (PMs) that were underway during the preceding 12 months as required in 42 CFR 438.240 (b)(2). This included:
3. A review to determine Magellan’s compliance with the requirements of 42 CFR 438.240 (a)(1), specifically deficiencies and/or recommendations identified in the 2007/2008 EQR audit.

- **Confirmation:** X Yes
- **Summary of results:** Overall Evaluation and Recommendations for Improvement states: “ this Plan is committed to providing a high level of service to their members with a commitment to timeliness, access and quality of care. In anticipation of a new review cycle requiring a full audit of all Quality Standards, focus on verification of documentation such as written procedures. This reviewer repeats the challenge to continue to commit program changes and improvement strategies to corporate culture and demonstrate sustained compliance.”
- **Problems identified:** Poor documentation of data extraction methodologies lead to complexity in consistent replication of the data. Data validation was determined.
- **Corrective action** (plan/provider level): Magellan should continue to focus on better documentation of the PIPs and PMs.
- **Program change** (system-wide level): None

m. X

Performance Improvement Projects [Required for MCO/PIHP]

X **Clinical**

- **Strategy:** Magellan maintains at least two Performance Improvement Projects at any given time.
- **Confirmation:** X Yes
- **Summary of results:**
The two 2009 PIPs are :
 - a) Decreasing the Severity of Depression for Consumers with Complex Health Needs through Behavioral Health and Medical Care Coordination.
Results if this project did not show statistically significant improvement from the baseline to the first remeasurement

year. The joint interventions appeared to assist clients in decreasing symptoms of depression but not at the goal rate.

b) Decreasing Inpatient Readmission Rates for Consumers with Schizophrenia and BiPolar Disorders Using Follow-up Nursing Visits.

Results of this project were did not show significant improvement although there was a decrease in readmission rate for this population between the baseline and remeasurement 1 year period. However there was an increase again in the readmission rate the following remeasurement year while the number of individuals receiving nuring services decreased.

- **Problems identified:** None
- **Corrective action** (plan/provider level): Continue PI(a) with a remeasurement time period of 7/1/09 to 6/30/10. For PI(b), the projet will continue to be reviewed by QIC. Continue to reference the CMS Protocol, “Conducting Performance Improvement Projects” in order to consistently integrate improved understanding of the project requirements.
- **Program change** (system-wide level): None

n. X

Performance Measures [Required for MCO/PIHP]

Process

Health status/outcomes

Access/availability of care

Use of services/utilization

Health plan stability/financial/cost of care

Health plan/provider characteristics

Beneficiary characteristics

- **Strategy:** The State has established a comprehensive list of Performance Indicators to monitor Magellan's implementation of the Iowa Plan.
- **Confirmation:** X Yes
- **Summary of results:** Magellan performance toward established Iowa Plan Performance Indicators has been reviewed by the QI Committee through monthly QI Workplans and was reported, as required, in quarterly and annual QI reports and to the Iowa Plan Advisory Committee and the Consumer/Family Advisory Committee.

Problems identified:

a) Monitoring Indicator #12: Quality of Care – ER visits per 1,000 enrollee months

Goal: ≤ 8.5 visits per 1,000 enrollee months

Magellan Performance (August 2009 QI Annual Report): 18.2 visits per 1,000

- **Corrective action** (plan/provider level): Participated in the DHS Acute Care Task Force and work with providers to generate ideas to reduce ER; specifically crisis stabilization services. Magellan will develop an RFP for Community Reinvestment to develop a pilot project(s) for crisis stabilization services.
- **Program change** (system-wide level): Findings from the project may be implemented network-wide, as appropriate.

p. X

Profile Utilization by Provider Caseload (looking for outliers)

X **Provider Profiling**

- **Strategy:** Magellan generates Provider Profiling each quarter for distribution to providers and analysis by Magellan and the State. Providers can pick up their Profiles from the MagellanofIowa.com website. In addition, they can review aggregate data for all providers in the Iowa network as well as the aggregate for like agencies; ie, CMHCs, facilities. The new version of Profiles that started January 2010 will include trended data for a two year period.
- **Confirmation:** X Yes
- **Summary of results:** Quarterly Provider Profiling was generated with provider-specific and network aggregate reports delivered to providers.
- **Problems identified:** Certain providers had higher than average rates of non-authorizations and claim denials than other providers.
- **Corrective action** (plan/provider level): Provider-specific technical assistance was conducted.
- **Program change** (system-wide level): In general, providers reported that profiling helped them identify problem areas and most providers responded with internal changes.

X **Provider Medication Monitoring**

- **Strategy:** Magellan works with the Drug Utilization Review Commission to monitor provider prescribing practices. Since January 1, 2010, Magellan has also received from the Iowa Medicaid Enterprise a data feed of drug claims by Medicaid Enrollee.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Magellan's Medical Director attends the State's Drug Utilization Review Commission (DUR) to assure coordination with the Iowa Plan and the fiscal agent that pays pharmacy.

- b) Monitoring Performance Indicator #21(August 2009 Annual Report): Psychotropic Medication
 Goal: Magellan shall screen all client admitted to inpatient for psychotropic medication use. If the medication is not appropriate, intervention will be made with the prescribing doctor.
 Magellan Performance: The percentage of clients using psychotropic medications at admission to inpatient ranged from 61.5% to 70.6% per month.
- c) Monitoring Performance Indicator #19 (August 2010 Annual Report the indicator was changed to:
 Goal: The Contractor shall identify medication utilization that deviates from current clinical practice guidelines; specifically, the Contractor shall report quarterly instances of three or more drugs in the same class being prescribed per enrollee.
 Magellan Performance: 23.6% in Qtr 1 and 21.4% in Qtr 2.
- d) Pharmacy data is incorporated into the Magellan IP system. The data download has allowed utilization of medication data for provider profiling and is available via the Magellan electronic medical record system for complementing case management of clients' required managed level of care and for those clients in the ICM program. The data will also be used to review use of pharmacy in different population groups in order to develop any needed strategies to ensure best practices.
- **Problems identified:** None
 - **Corrective action** (plan/provider level): None
 - **Program change** (system-wide level): Magellan is working closely with the provider network across the state to ensure medication are used properly and that clients are filling prescriptions as needed.

q. X

Provider Self-Report Data

 X **Survey of Providers**

- **Strategy:** Magellan administers a provider satisfaction survey each year.
- **Confirmation:** X Yes
- **Summary of results:**

a) Monitoring Performance Indicator #16 (2009) #8 (2010): Provider Satisfaction Survey (Also QI Workplan: Provider Satisfaction)
 Goal: Magellan will conduct an annual provider survey in which $\geq 75\%$ (2009) $> 80\%$ (2010) of network providers responding indicate satisfaction.

Magellan Performance (August 2010 QI Annual Report):
95% Overall Satisfaction in 08-09 and 95% Overall
Satisfaction in 09-10

- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X **Focus Groups**

- **Strategy:** Magellan conducts quarterly Provider Roundtables and providers are included in the quarterly Iowa Plan Advisory Committee and the quarterly Clinical Advisory Committee.
- **Confirmation:** **X** Yes
- **Summary of results:** Regularly scheduled Iowa Plan Provider Roundtables and advisory committee meetings were held. In addition, Magellan management staff attended regular meetings of Community Mental Health Centers and substance abuse organizations.
Magellan conducted trainings for Iowa Plan providers over Iowa's interactive fiber-optic network (ICN) as part of Iowa Plan Provider Roundtables:
 - April 16, 2009 – “STEPPS Treatment Program for Borderline Personality Disorder”
 - September 24, 2009 “Cultural Competency in Practice”
 - December 3, 2009 “A National Perspective on Peer Support:
 - March 4, 2010 “Providing Evidence Based Care to Older Iowans with Mental Illness”
 - December 1, 2010 “Latest Trends in Children’s Behavioral Health”
 - Numerous Webinars regarding the CHI and CHI-C Outcome Tools
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

s. **X** **Utilization Review** (e.g. ER, non-authorized specialist requests)

- **Strategy:** Magellan monitors all clinical activities including authorization/non-authorization of services and encounter data.
- **Confirmation:** **X** Yes
 - **Summary of results:** Utilization Review with Iowa-based Magellan clinical care management staff remained available 24 hours a day, 365 days a year. All utilization review was conducted in accordance with Iowa Plan Utilization Management

Guidelines (UMGs) and Iowa Plan policies. Annual review of the UMGs was conducted with the Clinical Advisory Committee. Current UMGs are made available to all providers and are available to members and families upon request.

Utilization review is monitored through Performance Indicators and the QI Workplan.

Examples of Performance Indicators and results related to utilization management include:

- a) Incentive Performance Indicator #1 Mental Health
Readmission Rates less than 15% (August 2009 Annual Report) and less than 14% (August 2010 Annual Report)
Magellan Performance: 14.1 August 2009 and 12.8% August 2010 Reports
- b) Incentive Performance Indicator #3 shall be not less than 60 days (August 2009 Annual Report) and #2 not less than 94 days (August 2010 Annual Report)
Magellan Performance: 78.5 days August 2009 and 95.9 days August 2010 Reports
- c) Incentive Performance Indicator: Service Array #5: At least 6% of mental health service expenditures will be used in the provision of integrated services and supports.
Magellan Performance (August 2009 QI Annual Report): 13.7%

Changed to PI # 3: At least 18% of mental health service expenditures will be used in the provision of integrated services and supports.

Magellan Performance (August 2010 Annual Report):13.2%

- d) Incentive Performance Indicator #6: Quality of Care (August 2009 QI Annual Report) and #4 (August 2010 QI Annual Report) (Also QI Workplan: 7-Day Ambulatory Follow-up)
Goal: $\geq 90\%$ of persons discharged from mental health inpatient will receive other treatment services in seven days.
Magellan Performance: (August 2009 QI Annual Report): 91.2% and 90% (2010 Annual Report)
- e) Incentive Performance Indicator #7 (2009) and #6 (2010):
Quality of Care
Goal: $>60\%$ of enrollees discharged from ASAM Levels III.5 and III.3 receive a follow-up substance abuse service in 14 days.
Magellan Performance: 73.9% and 81.4% respectively
- f) Penalty Performance Indicator #4: Quality of Care
Goal: $\geq 95\%$ of enrollees who received services in an emergency room and for whom inpatient was requested but not authorized shall have a follow-up contact in three business days of the date Magellan is notified of the ER service.

- Magellan Performance (August 2009 and 2010 QI Annual Reports): All Quarters between 100% and 98.4%
- g) Monitoring Performance Indicator #18: Dual Diagnosis
 Goal: Magellan will identify dually diagnosed clients admitted to inpatient or residential and track the follow-up services received.
 Magellan Performance (August 2009 QI Annual Report): Ranged from 30% to 58% of clients admitted to mental health inpatient received mental health and substance abuse follow-up services. Ranged from 10% to 62% of clients admitted to substance abuse inpatient who received mental health and substance abuse follow-up services. Note: This PI was eliminated in 2010.
- h) Monitoring Indicator #19: Emergency Room
 Goal: Magellan will monitor the number and percentage of clients presenting to the emergency room who had a service 30 days prior.
 Magellan Performance (August 2009 QI Annual Report): 37% to 47%. Note: This PI was eliminated in 2010.
- i) Monitoring Performance Indicator #22 – Quality of Care. Treatment of the Dually Diagnosed (Also QI WorkPlan: Dual Diagnosed Enrollee Follow-up).
 Goal: Magellan shall increase the percent of dually diagnosed enrollees discharged from an inpatient substance abuse and mental health treatment setting such that at least 40% of discharged enrollees receive both substance abuse and mental health treatment in 7 working days.
 Magellan Performance (August 2009 QI Annual Report): 12.4%

In 2010, it was changed to:

- Monitoring Performance Indicator #21 – Quality of Care: Treatment of the Dually Diagnosed (Also QI WorkPlan: Dual Diagnosed Enrollee Follow-up).
 Goal: Magellan shall increase the percent of dually diagnosed enrollees discharged from an inpatient substance abuse and mental health treatment setting such that at least 75% of discharged enrollees receive either a substance abuse or mental health treatment in 7 working days.
 Magellan Performance (August 2010 QI Annual Report): 6.1% to 17.8% monthly
- j) QI Workplan: Clinical Non-authorizations per 1,000
 Magellan Performance (August 2009 and August 2010 QI Annual Reports):
 Magellan Performance: 3.96 (August 2009 Report) and 5.93 (August 2010 Report) Clinical Non-authorizations per 1000

k) QI Workplan: Clinical Authorizations per 1,000
Magellan Performance (August 2009 and August 2010 QI
Annual Report): 152.63 (August 2009 Report) and 163.46
(August 2010 Report) clinical authorizations per 1000
members

Problems identified: There are a few PIs that Magellan is
continuing to develop plans in order to meet the targets.

Corrective action (plan/provider level): None

Program change (system-wide level): None

Section D – Cost-Effectiveness

- **Five Year Waiver Period SFY 2012 – SFY 2016**
- **Includes the Impact of Transitioning Habilitation Services to Managed Care and Removal of Targeted Case Management (TCM)**

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:

[Brad Neuweg](#)

c. Telephone Number: [515-281-0189](tel:515-281-0189)

d. E-mail: Bneuweg@dhs.state.ia.us

e. The State is choosing to report waiver expenditures based on x date of payment.

 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive

Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.

Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.

a. x The State provides additional services under 1915(b)(3) authority.

b. x The State makes enhanced payments to contractors or providers.

c. The State uses a sole-source procurement process to procure State Plan services under this waiver.

d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced*

payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b.**

- a. ___ MCO
- b. x PIHP
- c. ___ PAHP
- d. ___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a. ___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 - 1. ___ First Year: \$ ___ per member per month fee
 - 2. ___ Second Year: \$ ___ per member per month fee
 - 3. ___ Third Year: \$ ___ per member per month fee
 - 4. ___ Fourth Year: \$ ___ per member per month fee
- b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual

Waiver Cost. d.____ Other reimbursement method/amount. \$_____
Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a.____ Population in the base year data
 - 1.____ Base year data is from the same population as to be included in the waiver.
 - 2. ____ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b.____ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c.____ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

- d. ____ [Required] Explain any other variance in eligible member months from BY to P2: _____
- e.____ [Required] List the year(s) being used by the State as a base year: _____. If multiple years are being used, please explain:_____
- f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a. x [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. x For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. x [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
Member months were projected based on historical state experience in the base years by MEG.

d. [Required] Explain any other variance in eligible member months from BY/R1 to P2:

Eligible member month differences between the prospective and retrospective years are due to an expected increase in enrollment.

e. [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

R1=SFY2010; R2=SFY2011 Q1 and SFY2011 Q2. Since R2 is 6 months and P1 is annual, cell I15 on the D1. Member Months tab was annualized.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. _____ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

Remedial Services (RSP) moved from a FFS wraparound service to a capitated service. RSP remains in the State Plan Service column of the waiver spreadsheet. Applied Behavioral Analysis (ABA) services are included in RSP. These services were being renamed "Behavioral Health Intervention Services."

PMICs moved from a FFS wraparound service to a capitated service. This includes both in-state and out-of-state PMIC facility costs. Also included in the capitation rate are any ancillary services being provided to the patient while in the PMIC. PMICs remain in the State Plan Service column of the waiver spreadsheet.

Habilitation services (HAB) are moving from a FFS wraparound service to a capitated service effective 7/1/2013. HAB remains in the State Plan Service column of the waiver spreadsheet.

TCM services have been removed. An Administrative Services Organization (ASO) contract with the PIHP will be created.

Program adjustments were made on D5. Waiver Cost Projections.

b. _____ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:

All covered services (FFS wraparounds and capitated services) are included in the analysis.

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

| Additional Administration Expense | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|--|---|----------------------------|--|
| <i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i> | <i>\$54,264 savings or .03 PMPM</i> | <i>9.97% or \$5,411</i> | <i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i> |
| | | | |
| | | | |
| | | | |
| Total | <i>Appendix D5 should reflect this.</i> | | <i>Appendix D5 should reflect this.</i> |

The allocation method for either initial or renewal waivers is explained below:

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. x The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

Through a discussion between CMS and the State, it has been decided that the State may allocate all administrative costs to MEG 1.

- c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

In completing this assignment, Milliman has relied on data provided by the State of Iowa, its fiscal agent, and Magellan Behavioral Care of Iowa. We have reviewed this data for reasonableness but have not audited it.

If the data is flawed, our estimates will need to be revised.

CMS schedules D and F were used to determine the base year period costs. Schedule D provided a total payment amount for R1 (SFY 2010) and R2 (SFY 2011 Q1 and Q2) by MEG. Schedule F provided detail on the amounts paid for capitations, wraparounds, and administrative costs in the base years. State MEG reports and State Admin Form 64.10 data was used for detail, when needed. The split of capitations paid between State Plan services and B(3) services was based on the split contained in the actuarial reports for the corresponding rating periods. Base period member months were provided to us on the Eligible Member Months Report.

- a. x The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

State Narrative: 2.5% of the total capitation payment is placed into a Community Reinvestment account. In addition, additional services revenues not used for medical costs are also placed in the Community Reinvestment account per the contract. The Community Reinvestment account is used for Beneficiary Services and Provider Development/Customer Outreach as specified below.

Beneficiary Services: Up to 70% of the Community Reinvestment fund shall be used for direct services to enrollees. These shall be additional 1915(b)(3) services to enrollees as allowed under the cost savings aspect of the waiver. All such projects shall meet the prior

approval of the Department and CMS. The Department, at its sole discretion, may determine that funds in this category be used to increase provider payments so as to achieve enhanced access or maintain access as appropriate to meet the needs of the enrollees. Funds remaining in the enrollee services category shall continue to be held in the account to be used for direct services. Such funds that remain unspent or otherwise unencumbered will be returned to the Department at the termination of the contract.

Provider Development/Customer Outreach: Up to a maximum of 30% of the Community Reinvestment fund may be used for administrative services such as provider development and training, enrollee and family education, and outreach. Such activities shall be directed to enrollees or to the benefit of enrollees. Expenditures will be made only with the approval of the Department. – Note: these are not 1915(b)(3) funds – they are part of the entity’s administration costs.

Any funds remaining in the Provider Development/Customer Outreach category will be returned upon request to the Department at the end of each fiscal year. Note: these are not 1915(b)(3) funds – they are part of the entity’s administration costs.

The Department may require that any or all funding placed into the Community Reinvestment be returned to the Department upon notice. Federal matching funds will be refunded to CMS as required.

The contractor may not share any portion of the Community Reinvestment funding for the purpose of payment of administration or overhead of the program or as a profit. The PIHP is not required to set aside 2.5% of the RSP/Behavioral Health Intervention Services capitation payment for community reinvestment.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

| 1915(b)(3) Service | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|--|---|----------------------------|--|
| <i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from</i> | <i>\$54,264 savings or .03 PMPM</i> | <i>9.97% or \$5,411</i> | <i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i> |

| | | | |
|---|---|--|---|
| <i>inpatient hospital care. See attached documentation for justification of savings.)</i> | | | |
| | | | |
| | | | |
| Total | <i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i> | | (PMPM in Appendix D5 Column W x projected member months should correspond) |

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

| 1915(b)(3) Service | Amount Spent in Retrospective Period | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|-----------------------------------|--|
| <i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i> | <i>\$1,751,500 or \$.97 PMPM R1</i> <i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i> | <i>8.6% or \$169,245</i> | <i>\$2,128,395 or 1.07 PMPM in P1</i> <i>\$2,291,216 or 1.10 PMPM in P2</i> |
| B(3) services were not tracked separately in the base year. Please see | \$18,668,109 or \$4.51 PMPM R1 | -3.7% PMPM or approx. \$1,068,397 | \$21,163,215 or \$4.14PMPM P1 |

| | | | |
|---|--|---|--|
| <p>below a description of how the numbers were estimated.</p> | <p>\$10,047,409 (est \$20,094,818 per year) or \$4.30 PMPM R2</p> | <p>from R2 to P1 (R2 only has 2 quarters of data) 2.0% PMPM or \$2,015,477 from P1 to P2 -0.3% PMPM or \$1,646,214 from P2 to P3 -0.3% PMPM or \$1,777,767 from P3 to P4 -0.3% PMPM or \$1,920,979 from P4 to P5 Projected periods are impacted by the change in eligibility.</p> | <p>\$23,178,692 or \$4.22 PMPM P2 \$24,824,906 or \$4.21 PMPM P3 \$26,602,673 or \$4.20 PMPM P4 \$28,523,652 or \$4.18 PMPM P5 (these are projected PMPM costs for each MEG weighted by projected member months * projected member months per MEG. Please see table below for detail.)</p> |
| | | | |
| <p>Total</p> | <p>(PMPM in Appendix D3 Column H x member months should correspond)</p> | | <p>(PMPM in Appendix D5 Column W x projected member months should correspond)</p> |

The State does not track B(3) and State Plan capitations separately on the CMS schedules. The B(3) and State Plan capitation rates provided in the actuarial reports were used to split the capitations paid in the base year for cost-effectiveness purposes. The capitation rates were developed using encounter data and supplemental files containing community reinvestment expenditures. The information in the table above includes trend as well as the impact of any program changes.

The projected amounts in the table above are based on projected (not actual) member months.

| Year 1 | Projected Member Months | PMPM in Appendix D5 Column W |
|-------------------|-------------------------|---------------------------------|
| MEG 1 | 3,524,749 | \$2.14 |
| MEG 2 | 1,214,188 | \$10.83 |
| MEG 3 | 173,025 | \$2.18 |
| MEG 4 | 201,680 | \$0.49 |
| Weighted Avg PMPM | | \$4.14 |
| Total \$ | | \$21,163,215.35 |
| Year 2 | Projected Member Months | PMPM in Appendix D5 Column W |
| MEG 1 | 3,831,971 | \$1.98 |
| MEG 2 | 1,260,071 | \$11.92 |
| MEG 3 | 185,803 | \$2.47 |
| MEG 4 | 213,907 | \$0.54 |
| Weighted Avg PMPM | | \$4.22 |
| Total \$ | | \$23,178,692.27 |
| Year 3 | Projected Member Months | PMPM in Appendix D5 Column W |
| MEG 1 | 4,165,971 | \$2.01 |
| MEG 2 | 1,307,688 | \$12.10 |
| MEG 3 | 199,523 | \$2.51 |
| MEG 4 | 226,874 | \$0.54 |
| Weighted Avg PMPM | | \$4.21 |
| Total \$ | | \$24,824,906.12 |
| Year 4 | Projected Member Months | PMPM in Appendix D5 Column W |
| MEG 1 | 4,529,082 | \$2.05 |
| MEG 2 | 1,357,105 | \$12.27 |
| MEG 3 | 214,257 | \$2.55 |
| MEG 4 | 240,628 | \$0.55 |
| Weighted Avg PMPM | | \$4.20 |
| Total \$ | | \$26,602,672.76 |
| Year 5 | Projected Member Months | PMPM in Appendix D5 Column W |
| MEG 1 | 4,923,843 | \$2.08 |
| MEG 2 | 1,408,389 | \$12.44 |
| MEG 3 | 230,079 | \$2.60 |
| MEG 4 | 255,216 | \$0.56 |
| Weighted Avg PMPM | | \$4.18 |
| Total \$ | | \$28,523,652.01 |

- b. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- c. x Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. x The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to [provide for insolvency issues](#). No adjustment was necessary.

The current PIHP (MBCI) is an LSO in the State of Iowa. The LSO status is monitored and reviewed by the Iowa Department of Commerce, Division of Insurance. Iowa Administrative Rules require LSOs to maintain an insolvency plan. According to the plan, the LSO must maintain significant positive equity. Significant positive equity is defined as 200% of the risk based capital. IF an LSO has 150% to 200% equity, the LSO must submit a plan to reach 200% to the Division of Insurance. If the equity is below 150%, the Division of Insurance may provide oversight and advice on the day-to-day operation and is actively involved with the LSO.

In addition to the significant positive equity, the current PIHP (MBCI) is required, as a contract condition, to maintain an insolvency account. This is a custodial account that the State has access to should the PIHP default. The amount in the account covers the outstanding debt at any given time.

2. ___ The State provides stop/loss protection (please describe):

- d. x Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

In SFY 2010 Q3 (ending 3/31/2010), a \$1,000,000 incentive payment was made. In SFY 2011 Q1 (ending 9/30/2010), a \$500,000 incentive payment was made to the PIHP.

2. For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
1. ____ [Required, if the State’s BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ____ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used _____. Please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ___ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
 - Reductions in State Plan Services (-)
 - Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)
1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
 2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Determine adjustment for Medicare Part D dual eligibles.
 - E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- iv. ___ Changes in legislation (please describe):
- For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. ___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

- 1. ___ No adjustment was necessary and no change is anticipated.
- 2. ___ An administrative adjustment was made.
 - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

- B. ____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. ____ Other (please describe):
- ii. ____ FFS cost increases were accounted for.
 - A. ____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ____ Other (please describe):
- iii. ____ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
 - 1. ____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to*

present). The actual documented trend is: _____. Please provide documentation.

- 2.____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

- 1.____ We assure CMS that GME payments are included from base year data.
- 2.____ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
- 3.____ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

- 1.____ GME adjustment was made.
 - i.____ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii.____ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
- 2.____ No adjustment was necessary and no change is anticipated.

Method:

- 1.____ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
- 2.____ Determine GME adjustment based on a pending SPA.
- 3.____ Determine GME adjustment based on currently approved GME SPA.
- 4.____ Other (please describe):

- g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.
1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
 2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
 3. ___ The State had no recoupments/payments outside of the MMIS.

- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine copayment adjustment based on pending SPA.
3. ___ Determine copayment adjustment based on currently approved copayment SPA.
4. ___ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will

delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ___ No adjustment was necessary
 2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
 3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
 4. ___ The State made this adjustment:*
- i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
 - ii. ___ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5.**
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. ___ Other (please describe):

- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. ___ We assure CMS that DSH payments are excluded from base year data.
2. ___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ___ Other (please describe):

1. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
 1. ___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
 2. ___ This adjustment was made:
 - a. ___ Potential Selection bias was measured in the following manner:
 - b. ___ The base year costs were adjusted in the following manner:

- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
 1. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
 2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
 3. ___ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
 4. ___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and

excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

| Adjustment | Capitated Program | PCCM Program |
|---------------------------|--|--|
| Administrative Adjustment | The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column) | The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness). |

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.

- 1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner

on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 3. ___ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 2. ___ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection,

that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. x [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: 10.4% * for all MEGs for R2 to P1; 6.3%* for all MEGs for P1 to P2; 5.1% for all MEGs for P2 to P3; 5.2% for all MEGs for P3 to P4; and 5.2% for all MEGs for P4 to P5. Please document how that trend was calculated:

*R2 to P1 is the difference between actual payments made in R2 versus actual payments in P1. P1 to P2 includes the difference between actual payments in P1 and expected payments in P2. The estimated payments in P2 is based on actual payments for the first two quarters plus assumed trend.

The State Plan capitations trend was based on linear regression of the monthly encounter data. Only State Plan services were used in this calculation. The wraparound trend was based on the historical MEG PMPM MH-Rx costs as reported in the MEG reports.

For B(3) capitations, the trend used to estimate the P1 (SFY 2012) and P2 (SFY 2013) rates was limited to the State Plan (State Plan capitations + wraparounds) trend.

2. x [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are

predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

- i. x State historical cost increases. Please indicate the years on which the rates are based: base years [R1=SFY 2010; R2=SFY 2011Q1 and Q2](#). In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. ([see above](#))
- ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

b. x **State Plan Services Programmatic/Policy/Pricing Change Adjustment:**

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)

- Reductions in State Plan Services (-)
 - Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
 - Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
 - Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.
1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. x An adjustment was necessary and is listed and described below:
- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ *Determine adjustment for Medicare Part D dual eligibles.***
 - E. ___ Other (please describe):**
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
 - iv. ___ Changes brought about by legal action (please describe): For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

- C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
- D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):
- a. ___x___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - a. ___x___ Other (please describe):

Pharmacy Rebate Factor – Rebates decrease the State’s program costs for prescription drugs. An adjustment was made to account for drug rebates not excluded from the base year paid data. Prescription drug rebate information was not available specifically for the Iowa Plan. As requested by CMS, the ratio of IA Plan Prescription Drug costs to Total Prescription Drug Expenditures for the entire program was used to estimate the percentage of Drug Rebates that would have been expected in the Iowa Plan. The adjustment reduces state plan costs in P1 and is then carried forward to the other prospective periods.

Incentive Factor –The incentive payment expected in P1 is \$1,000,000. In the past, incentive payments were allocated across all MEGs based on total capitations paid. Per CMS, the State is now allowed to allocate the incentives to one MEG. An adjustment has been made to increase the state plan costs by allocating future incentive payments to MEG 1 FMAP.

RSP/Behavioral Health Intervention Services – These services have been moved from a FFS wraparound payment to a capitated service. ABA services are included in the capitation payment made to the PIHP. RSP services remain in the State Plan Services column of the waiver spreadsheet. An adjustment has been made to reflect management of care.

PMIC Services – PMIC services were moved from a FFS wraparound payment to a capitated service on July 1, 2012. This includes out-of-state PMIC providers. Also, the

costs of ancillary services provided to the individual while in the PMIC were also included in the capitation payment made to the PIHP. An adjustment has been made to reflect potential savings through the use of a network in the out-of-state PMICs.

HAB Services – HAB services are being moved from a FFS wraparound payment to a capitated service with an expected implementation date of July 1, 2013. HAB remains in the State Plan Services column of the waiver spreadsheet.

TCM services – TCM services were removed from the Iowa Plan waiver.

The state is making a change to its pharmacy reimbursement. The change is expected to achieve a savings of 1.25%.

The overall impact of these adjustments is -4.5% in P1 and -2.8% in P3. The adjustments are carried forward to the other prospective years.

c. **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. No adjustment was necessary and no change is anticipated.

2. An administrative adjustment was made.

i. Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii. Cost increases were accounted for.

A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. State Historical State Administrative Inflation. The actual trend rate used is: _____ . Please document how that trend was calculated:

D. Other (please describe): _____

Per the state, “The projected admin allocations to the Iowa Plan are \$8.3M (total dollars) in both FFY 13 & 14. The higher amounts are

driven by a higher allocation percentage, which is based on claim volume, and overall increased admin expenses, mainly due the large projects of replacing the MMIS and eligibility system.” No increase is expected in future years.

- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. x [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is:

| | P1 | P2 | P3-P5 |
|--------------|-------|-------|-------|
| MEG 1 | 4.7% | -7.5% | 1.7% |
| MEG 2 | -5.1% | 10.1% | 1.4% |
| MEG 3 | -2.0% | 13.1% | 1.7% |
| MEG 4 | 16.5% | 9.0% | 1.7% |

Please provide documentation.

R2 to P1 is the difference between actual payments made in R2 versus actual payments in P. P1 to P2 includes the difference between actual payments in P1 and expected payments in P2. The estimated payments in P2 is based on actual payments for the first two quarters plus assumed trend.

When calculating the B(3) capitation rates, the trend rate for B(3) services was limited to the lower of the combined State Plan (State Plan capitated services plus wraparounds) and the historical B(3) trend by MEG.

The trend used in the capitation rates development was based on linear regression of the monthly encounter data. Only state plan services were used in this calculation. The wraparound trend was based on the historical expenditures reported in the State MEG reports.

2. x [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
 - i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years R1=SFY 2010; R2=SFY 2011 Q1 and Q2.
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
 - ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
 1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.**
 3. _____
Explain any differences:
- f. **Other Adjustments** including but not limited to federal government changes. (Please describe):
 - If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
 - Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only

include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. ___ Other (please describe):

1. ___ No adjustment was made.
2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**: Member months were projected based on historical State experience in the base years by MEG.
2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:
The cost-effectiveness demonstration includes the change from the base year rates to the anticipated prospective year rates. The trends for capitated services were based on utilization and cost trends. Trends for the wraparound services were based on the historical experience of the FFS costs reported on the MEG reports with actuarial judgment. The trend rate for B(3) services was limited to lower of the combined State Plan services plus wraparounds and the historical B(3) trend by MEG.
3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

For State Plan capitations, the trend was based on linear regression of the monthly encounter data. This resulted in a historical annual trend rate of approximately 3.7%. Only State Plan services were used in this calculation.

The trend rate for B(3) services was limited to the lower of the combined State Plan services plus wraparounds and historical B(3) trend by MEG.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Additional factors affecting the rates include program changes, incentive payments, administration costs, and caseload mix.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.