Section D – Cost-Effectiveness

Amendment 1: June 2022

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.

Text highlighted in blue within Section D of the preprint narrative represents adjustments that were made as part of Amendment 1. The purpose of Amendment 1 is to revise the P2-P5 projections to account for the policy changes associated with the SFY22 legislative appropriations and the CMS approved, University of Iowa Hospitals and Clinics (UIHC) Average Commercial Rate (ACR) Hospital state-directed payment. Adjustments have been made to the P2 projection period, effective July 1, 2022, to account for these program changes which were effective July 1, 2021. The PMPMs for subsequent projection periods are also impacted as these policies are expected to continue annually through P5.

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:
Elizabeth Matney, Medicaid Director

c. Telephone Number: 515-256-4640

d. E-mail: ematney@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.___ 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._**X**_ MCO
b.___ PIHP
c.___ PAHP
d.___ Other (please explain):

The Section D Appendices reflect the IA Health Link program that began providing services on April 1, 2016. The R1 and R2 time periods are SFY19 and SFY20 YTD (July 1, 2019 – March 31, 2020) based on data available at the time of the preprint completion.

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):

Not applicable.

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: **Not applicable.**

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.

The only change in population from the prior waiver submission to the current waiver is the removal of the §1115 Iowa Family Planning Demonstration Enrollees. This demonstration ended on June 30, 2017 so no information was included within the service or administration costs of the R1 and R2 (SFY19 and SFY20 YTD) time periods.

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:

Membership projections to P1 are estimated by applying the quarterly growth from the average quarterly enrollment in R2 (July 1, 2019 – March 31, 2020) to the first quarter of P1 (April 1, 2021 – June 30, 2021). The following table shows the quarterly increase of membership that was used within Appendix D to capture anticipated enrollment changes throughout the waiver projection period:

MEG	Quarterly Growth %
TANF	0.50%
Expansion	0.50%
Family Planning	0.50%
Aged/Blind/Disabled Non-Dual	0.50%
Aged/Blind/Disabled Dual	0.50%
LTSS - Elderly	0.25%
LTSS - Non-Dual and/or Pre-65	0.25%
LTSS - Intellectual Disability	0.25%
LTSS - Children's Mental Health	0.25%

The member month projections are based on the average growth of historical Iowa Health Link experience for each MEG.

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

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

The R1 and R2 time periods are SFY19 (July 1, 2018 – June 30, 2019) and SFY20 YTD (July 1, 2019 – March 31, 2020), respectively.

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

For Initial Waivers: **Not applicable.**

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._**X**_ [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**:

The covered services within the previous waiver submission and the renewal waiver are consistent. There are two program adjustments within Appendix D5 to account for the following:

- **Pharmacy Rebate Adjustment:**
  Within the 4th Quarter of Federal Fiscal Year 2019 (FFY19 Q4) pharmacy drug rebate collections were approximately double normal quarterly collections due to a number of prior period adjustments. Collections in FFY19 Q4 were around $180M, but IME's normal quarterly rebate totals are usually within the range of $90M - $100M. FFY19 Q4 is inherent within the R2 base data period used for projections, but future periods are not expected to have significant amounts of prior period adjustments. Since the CMS-64s are reported on a paid basis and the overstatement of pharmacy rebates results in understated medical costs for that time period, an adjustment was made to increase the expected service costs by 2.0% (or $85M for the quarter). These additional costs were allocated based on the distribution of R2 pharmacy rebates across the MEGs and result in net pharmacy rebates around $95M for FFY19 Q4, which are in line with normal levels of quarterly rebate collections and future expectations. Without this adjustment, the P1 – P5 projections would be understated as a result of unusually high pharmacy rebate collections within the

R2 base period that are not expected to occur within future contract periods.

- **Hepatitis C Adjustment:**
  Effective July 1, 2020, DHS/IME implemented a policy change to remove the Hepatitis C Fibrosis Score criteria required to receive treatment for Hepatitis C within Iowa Medicaid. Using internal IME estimates, the R2 service costs have been increased by about 0.6% in aggregate (about $27M annually) within the program change adjustment within Section D Appendix 5. The variation by MEG is based on the distribution of members within the Health Link program that are diagnosed with Hepatitis C.

The combined impact of these program adjustments is an aggregate 2.6% increase to the waiver projections within Appendix D5 (cells M13-M22), with variation by MEG based on actual and expected service utilization.

The P2 projection, effective July 1, 2022, has been amended to account for policy changes associated with the SFY22 legislative appropriations, effective July 1, 2021, as well as the implementation of the UIHC ACR Hospital state-directed payment. These legislative policy changes and the UIHC ACR directed payment are expected to continue in future projection periods so have been implemented as program adjustments in the P2 projection based on the timing of implementation for each program change.

Updates have been made to the P2 program adjustment section for the State Plan Services impacted by these program changes in cells M34-M41 of Appendix D5. Three additional columns, AB-AD, were inserted in the 1915(c) Services section to account for the HCBS Appropriation described below. Subsequent columns of the Appendix D5 template after the 1915(c) Services have shifted accordingly. Any cells in Appendix D that have light orange shading indicate sections that have been revised as part of Amendment 1. Changes have only been made to the program change adjustment sections of the State Plan Services and 1915(c) Services portions of Appendix D5. The base period, 1915(b)(3) Services, inflation adjustments, and administrative costs remain unchanged from the original renewal submission.

The following SFY22 legislative appropriation adjustments are accounted for within the program adjustments shown in cells M34-M41 for the applicable State Plan Services, while the 1915(c) Services are adjusted in cells AB34-AB41 which were newly added in this amendment. The SFY22 legislative appropriations are effective July 1,

2021. Effective July 1, 2022, the P2 projection has been adjusted for these program changes in the amended Appendix D5. A brief description of each legislative appropriation is discussed below:

- **Air Ambulance Fee Increase: Base reimbursement per trip for certain air ambulance procedure codes increased from $250.35 to $550.00.**

- **Dispensing Fee Increase: IME increased the pharmacy dispensing fee for all pharmacy providers, both local and national chains, from $10.07 to $10.38 per script, or approximately 3.1%.**

- **Home-Based Habilitation Appropriation: New Home-Based Habilitation (HBH) rates will be paid to providers. The current 6-tier reimbursement structure of the HBH program will have a 7th tier added for members who require the most intensive residential care needs with 24 hours of direct care received per day. Members will be classified into the 7 HBH tiers using a new Level of Care Utilization System (LOCUS) assessment to match the client's clinical needs with the tiered reimbursement structure.**

- **HCBS Appropriation: All Home and Community Based Services (HCBS), excluding the Home-Based Habilitation services noted above, received a 3.55% increase in reimbursement.**

    - ***Note: This adjustment is reflected in cells AB34-AB41 of the 1915(c) Services section, while the combined impact of the other appropriations are reflected in cells M34-M41.***

- **Home Health LUPA Appropriation: Services impacted by the Home Health Low Utilization Payment Adjustment (LUPA) received a rate increase as a result of the legislative appropriations.**

- **Nursing Facility Appropriation: Nursing facility providers received a reimbursement increase for services rendered to the IA Medicaid population as a result of the legislative appropriations. While the increase for individual providers varies, the average nursing facility provider received an increase of approximately 7.0%.**

- **PMIC Appropriation: The reimbursement for Psychiatric Medical Institutions for Children (PMICs) services increased by 52%.**

The aggregate impact to P2 associated with the non-HCBS appropriations and directed payment is a 9.7 increase to State Plan Services shown in cell M43, with variation by MEG. The aggregate impact of the HCBS Appropriation can be found in cell AB43 and is an increase of 3.55% to the 1915(c) Services in the P2 projection period.

The directed payment component includes the CMS approved UIHC ACR state-directed payment for inpatient and outpatient hospital services. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule) calculated using an ACR payment-to-charge ratio for inpatient and outpatient hospital services. This directed payment will be operationalized as a separate payment term. Although the UIHC ACR payments are effective beginning July 1, 2021, the reconciliation payments were scheduled to be paid the quarter after they are incurred. Due to the approval of the SFY22 capitation rates in March and April 2022, the state will process payments for the July 1, 2021 to March 31, 2022 periods in the April 1, 2022 to June 30, 2022 period. The P2 projection has been updated effective July 1, 2022.

Estimates from the SFY22 IA Health Link rate development were used as the basis for developing the percent adjustments for all program changes noted within this amendment. The legislative appropriations were applied to the P2 period, effective July 1, 2022. Similarly, for the UIHC ACR Hospital directed payment the estimated rate impact was applied to P2, effective July 1, 2022, due to the operational timing associated with the directed payments. No offsetting reductions were made in subsequent projection periods since these payments are expected to continue in the future.

b._ **X**_ [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:

Consistent with the prior waiver submission, Dental, School-Based, Money Follows the Person, and Iowa Veteran's Home services are not included in the waiver as they are not covered via the IA Health Link

Managed Care program. State supplemental payments to members residing at Residential Care Facilities are also excluded.

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: **Not applicable.**

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
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

a._**X**_ 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.*

The quarterly CMS-64.10 data by MEG is used as the basis for Appendix D2.A and reflects the administrative allocation based on the number of waiver enrollees for each MEG as a percentage of total Medicaid enrollees.

b.___ 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.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

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.

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**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(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
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Intensive Psychiatric Rehabilitation	**R1 -- $0.37 PMPM** **R2 -- $0.41 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.43 PMPM in P1** **$0.45 PMPM in P2** **$0.46 PMPM in P3** **$0.48 PMPM in P4** **$0.50 PMPM in P5**
Community Support - Low	**R1 -- $0.32 PMPM** **R2 -- $0.30 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.32 PMPM in P1** **$0.33 PMPM in P2** **$0.34 PMPM in P3** **$0.35 PMPM in P4** **$0.36 PMPM in P5**
Community Support - High	**R1 -- $0.13 PMPM** **R2 -- $0.11 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.11 PMPM in P1** **$0.12 PMPM in P2** **$0.12 PMPM in P3** **$0.13 PMPM in P4** **$0.13 PMPM in P5**
Peer Support	**R1 -- $0.05 PMPM** **R2 -- $0.05 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.06 PMPM in P1** **$0.06 PMPM in P2** **$0.06 PMPM in P3** **$0.06 PMPM in P4** **$0.07 PMPM in P5**
Integrated Services	**R1 -- $0.00 PMPM**	**3.9% Annual**	**$0.00 PMPM in P1**

and Supports (Wrap-around services)	**R2 -- $0.00 PMPM**	**Trend for P1-P5**	**$0.00 PMPM in P2 $0.00 PMPM in P3 $0.00 PMPM in P4 $0.00 PMPM in P5**
Respite	**R1 -- $0.00 PMPM R2 -- $0.00 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.00 PMPM in P1 $0.00 PMPM in P2 $0.00 PMPM in P3 $0.00 PMPM in P4 $0.00 PMPM in P5**
Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Abuse	**R1 -- $0.46 PMPM R2 -- $0.49 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.53 PMPM in P1 $0.55 PMPM in P2 $0.57 PMPM in P3 $0.60 PMPM in P4 $0.62 PMPM in P5**
Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Treatment Substance Abuse	**R1 -- $0.15 PMPM R2 -- $0.19 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.20 PMPM in P1 $0.21 PMPM in P2 $0.22 PMPM in P3 $0.23 PMPM in P4 $0.24 PMPM in P5**
Level III.3 & III.5 Clinically Managed Medium/High Intensity Residential Treatment Substance Abuse Hospital Based	**R1 -- $0.95 PMPM R2 -- $1.10 PMPM**	**3.9% Annual Trend for P1-P5**	**$1.19 PMPM in P1 $1.24 PMPM in P2 $1.29 PMPM in P3 $1.34 PMPM in P4 $1.39 PMPM in P5**
Level III.7 Substance Abuse Residential Community-based	**R1 -- $0.00 PMPM R2 -- $0.02 PMPM**	**3.9% Annual Trend for P1-P5**	**$0.02 PMPM in P1 $0.02 PMPM in P2 $0.02 PMPM in P3 $0.02 PMPM in P4 $0.02 PMPM in P5**
Total	**R1 -- $2.44 PMPM R2 -- $2.66 PMPM**	**3.9% Annual Trend for P1-P5**	**$2.86 PMPM in P1 $2.97 PMPM in P2 $3.09 PMPM in P3 $3.21 PMPM in P4 $3.33 PMPM in P5**

The amounts included within the table above are aggregate PMPMs across all MEGs. The annual inflation projection for 1915(b)(3) services varies by MEG, but the table shows aggregate projection factors across all MEGs. The trends for each MEG can be found in Section J.D. below.

b.**_X_** 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:

The Alaskan Native and American Indian populations are the only populations that are voluntarily enrolled with the MCOs. A selection adjustment is not necessary because of the small size of the population.

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 purchase reinsurance coverage privately~~ **to provide for insolvency issues.** No adjustment was necessary.

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

The MCOs must comply with the requirements at Iowa Admin Code r. 191-40.17(514B).

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

Not applicable. There are no incentive/bonus/enhanced payments to the MCOs for the Health Link managed care program.

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.

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.

Not applicable as this is a Renewal Waiver.

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):

l. **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: **3.4% annually in aggregate with variation by MEG**. Please document how that trend was calculated:

In order to calculate the State Plan Inflation Adjustment PMPMs for P1, the 3.4% annual aggregate trend is applied from the midpoint of the R2 period (July 1, 2019 – March 31, 2020) to the midpoint of P1 (April 1, 2021 – March 31, 2022). The State Plan annual trends vary by MEG but are consistent across all five years of the waiver projection and result in a 3.4% annual trend for P1 and a 3.5% annual trend in P2-P5.

The annual trends developed during the IA Health Link managed care capitation rate setting process were used as the basis for trending the cost of services covered under the waiver from the R2 experience period forward to P1-P5. The rating trends inherent in the capitation rates for State Plan Services, 1915(b)(3) Services, and 1915(c) Services serve as the basis for the actual trend rates used to project the R2 experience forward through P5. In general, trend development in the capitation rate setting process utilizes 3, 6, and 12 month moving averages (MMA) when analyzing the course of the historical SFY18-SFY20 YTD IA Health Link experience, but there is no predetermined algorithm used for all populations and services.

The Pharmacy Rebate and Hepatitis C adjustments were the only known program changes that impact the waiver at this time. These adjustments were calculated and applied separately as an adjustment to P1 to avoid duplication with trend projections.

The adjustments for the SFY22 Appropriations and UIHC ACR Hospital state-directed payment were calculated and applied

separately within cells M34-M41 and AB34-AB41 to avoid duplication with trend projections.

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 **historical IA Health Link MCO experience for the SFY18 - SFY20 YTD time periods was evaluated as part of the trend projections. The trend rates used for waiver projection are the same as those used in the actuarially sound capitation rate development process.** 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.

The State Plan Service trend adjustment reflects an overall annual trend of 3.4% applied from the midpoint of R2 (11/15/2019) to the midpoint of P1 (9/30/2021). The annual trend projection varies by MEG. The remaining P2-P5 projection periods rely on the same annual trend factors but vary by service type. The P1-P5 annual trends are consistent with trend assumptions used in the development of capitation rates for the IA Health Link program. These trends vary by rating cohort and service category but have been mapped into the respective MEGs and Service Types (State Plan, 1915(b)(3), and 1915(c)) outlined in the waiver template. The projected trends are PMPM trends that include the combined changes in practice patterns, units of service, and utilization.

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. **_X_** 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. **_X_** Other (please describe):

Within the 4th Quarter of Federal Fiscal Year 2019 (FFY19 Q4) pharmacy drug rebate collections were approximately double normal quarterly collections due to a number of prior period adjustments. Collections in FFY19 Q4 were around $180M, but IME's normal quarterly rebate totals are usually within the range of $90M - $100M. FFY19 Q4 is inherent within the R2 base data period used for projections, but future periods are not expected to have significant amounts of prior

period adjustments. Since the CMS-64s are reported on a paid basis and the overstatement of pharmacy rebates results in understated medical costs for that time period, an adjustment was made to increase the expected service costs by 2.0% (or $85M for the quarter). These additional costs were allocated based on the distribution of R2 pharmacy rebates across the MEGs and result in net pharmacy rebates around $95M for FFY19 Q4, which are in line with normal levels of quarterly rebate collections and future expectations. Without this adjustment, the P1 – P5 projections would be understated as a result of unusually high pharmacy rebate collections within the R2 base period that are not expected to occur within future contract periods.

Effective July 1, 2020, IME completely removed the Fibrosis Score requirements to receive Hepatitis C drug treatments for the IA Health Link population. This loosening of requirements is expected to increase the service utilization associated with Hepatitis C treatment drugs. The policy change came into effect between the R2 base period and P1 projection period so an adjustment is necessary to account for the additional cost of services expected to occur during the waiver projection period. Using internal IME estimates an increase of 0.6% has been added to the P1 projection period to account for this policy change.

The combined impact of the Pharmacy Rebate and Hepatitis C adjustment is a 2.6% increase to the P1 projection period. No additional adjustments were made for subsequent years of the waiver projection because no other upcoming policy changes are known at this time.

The P2 projection has been amended to account for policy changes associated with the SFY22 legislative appropriations, effective July 1, 2021, as well as the implementation of the UIHC ACR Hospital state-directed payment. These legislative policy changes and the UIHC ACR directed payment are expected to continue in future projection periods so have been implemented as program adjustments in the P2 projection, effective July 1, 2022, based on the timing of implementation for each program change.

Updates have been made to the P2 program adjustment sections for the State Plan Services impacted by these program changes in cells M34-M41 of Appendix D5. Three additional columns, AB-AD, were inserted in the 1915(c) Services section

to account for the HCBS Appropriation described below. Subsequent columns of the Appendix D5 template after the 1915(c) Services have shifted accordingly. Any cells in Appendix D that have light orange shading indicate sections that have been revised as part of Amendment 1. Changes have only been made to the program change adjustment sections of the State Plan Services and 1915(c) Services portions of Appendix D5. The base period, 1915(b)(3) Services, inflation adjustments, and administrative costs remain unchanged from the original renewal submission.

The following SFY22 legislative appropriation adjustments are accounted for within the program adjustments shown in cells M34-M41 for the applicable State Plan Services, while the 1915(c) Services are adjusted in cells AB34-AB41 which were newly added in this amendment. The SFY22 legislative appropriations are effective July 1, 2021. Effective July 1, 2022, the P2 projection has been adjusted for these program changes in the amended Appendix D5. A brief description of each legislative appropriation is noted below:

- **Air Ambulance Fee Increase: Base reimbursement per trip for certain air ambulance procedure codes increased from $250.35 to $550.00.**

- **Dispensing Fee Increase: IME increased the pharmacy dispensing fee for all pharmacy providers, both local and national chains, from $10.07 to $10.38 per script, or approximately 3.1%.**

- **Home-Based Habilitation Appropriation: New Home-Based Habilitation (HBH) rates will be paid to providers. The current 6-tier reimbursement structure of the HBH program will have a 7th tier added for members who require the most intensive residential care needs with 24 hours of direct care received per day. Members will be classified into the 7 HBH tiers using a new Level of Care Utilization System (LOCUS) assessment to match the client's clinical needs with the tiered reimbursement structure.**

- **HCBS Appropriation: All Home and Community Based Services (HCBS), excluding the Home-Based Habilitation services noted above, received a 3.55% increase in reimbursement.**

- ***Note: This adjustment is reflected in cells AB34-AB41 of the 1915(c) Services section, while the combined impact of the other appropriations are reflected in cells M34-M41.***

- **Home Health LUPA Appropriation: Services impacted by the Home Health Low Utilization Payment Adjustment (LUPA) received a rate increase as a result of the legislative appropriations.**

- **Nursing Facility Appropriation: Nursing facility providers received a reimbursement increase for services rendered to the IA Medicaid population as a result of the legislative appropriations. While the increase for individual providers varies, the average nursing facility provider received an increase of approximately 7.0%.**

- **PMIC Appropriation: The reimbursement for Psychiatric Medical Institutions for Children (PMICs) services increased by 52%.**

The aggregate impact to P2 associated with the non-HCBS appropriations and directed payment is a 9.7% increase to State Plan Services shown in cell M43, with variation by MEG. The aggregate impact of the HCBS Appropriation can be found in cell AB43 and is an increase of 3.55% to the 1915(c) Services in the P2 projection period.

The directed payment component includes the CMS approved UIHC ACR state-directed payment for inpatient and outpatient hospital services. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule) calculated using an ACR payment-to-charge ratio for inpatient and outpatient hospital services. This directed payment will be operationalized as a separate payment term. Although the UIHC ACR payments are effective beginning July 1, 2021, the reconciliation payments were scheduled to be paid the quarter after they are incurred. Due to the approval of the SFY22 capitation rates in March and April 2022, the state will process payments for the July 1, 2021 to March 31, 2022 periods in the April 1, 2022 to June 30, 2022 period. The P2 projection has been updated effective July 1, 2022.

Estimates from the SFY22 IA Health Link rate development were used as the basis for developing the percent adjustments for all program changes noted within this amendment. The legislative appropriations were applied to the P2 period, effective July 1, 2022. Similarly, for the UIHC ACR Hospital directed payment the estimated impact from rate development was applied to P2, effective July 1, 2022, due to the operational timing associated with the directed payments. No offsetting reductions were made in subsequent projection periods since these payments are expected to continue in the future.

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. **_X_ 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._**X**_ 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._**X**_ 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._**X**_ State Historical State Administrative Inflation. The actual trend rate used is: **4.0% annually.** Please document how that trend was calculated:

An annual trend rate of 4.0% was used to project R2 admin base period costs to P1-P5, consistent with historical and expected state administrative cost increases. The inflation adjustment from R2 to P1 is 4.0% annually, and was applied from the midpoint of R2 (11/15/2019) to the midpoint of P1 (9/30/2021) with the formula adjustment highlighted within the waiver template. Throughout the waiver projection period, DHS/IME expect to upgrade their Medicaid Management Information System (MMIS). The system upgrade is expected to cost an average of $20M per year over the next 5 years. Within Appendix D5 (cells AD13 – AD22), an annual adjustment of $20M for these additional administrative costs associated with the MMIS upgrade been included within the P1 inflation factor. Subsequent years have the MMIS upgrade costs inherent within the projection as a result of this initial adjustment in P1. Thus, the inflation adjustment for the remaining P2-P5 projection years is the 4.0% noted previously. No other admin expenses for upcoming projects were included within the Appendix D template outside of the anticipated MMIS upgrade.

D.____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.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: **3.9% for the 1915(b)(3) services in aggregate, with variation by MEG. The trend applied to each MEG is the lesser of 1915(b)(3) Service specific trends and the State Plan Service trends.** Please provide documentation.

Actual IA Health Link managed care capitation rate trends were used to project the cost of services covered under the waiver. These trends vary by rating cohort and service category but have been mapped into the respective MEGs and Service Types (State Plan, 1915(b)(3), and 1915(c)) outlined in the waiver template. The projected trends are PMPM trends that include the combined changes in practice patterns, units of service, and utilization.

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 **are historical IA Health Link MCO experience for the SFY18 - SFY20 YTD time periods. The trend rates used for waiver projection are the same as those used in the actuarially sound capitation rate development process for each service type and MEG.**
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
In general, trend development in the capitation rate setting process utilizes linear regression and 3, 6, and 12 month moving averages (MMA) when analyzing trends.

The historical SFY18-SFY20 YTD IA Health Link experience is the basis of the trend development, but there is no predetermined algorithm used for all populations and services.

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above **3.4%**.

The 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service experience and the State Plan Service trend. In aggregate, the 1915(b)(3) Service trend is 3.9% annual, while the State Plan Service trend is 3.4%. However, the 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service trends and State Plan Services trends and this difference is just due to the differences in service mix between the MEGs. The following table shows the annual trends for the 1915(b)(3) and State Plan Services and the lesser of 1915(b)(3) trend that was used to populate Appendix D5.

	Annual PMPM Trends		
MEG	**1915(b)(3)**	**State Plan**	**Final 1915(b)(3) Used**
TANF	3.7%	4.0%	**3.7%**
Expansion	4.8%	4.6%	**4.6%**
Aged/Blind/Disabled Non-Dual	4.9%	4.2%	**4.2%**
Aged/Blind/Disabled Dual	3.7%	2.7%	**2.7%**
LTSS - Elderly	3.7%	1.5%	**1.5%**
LTSS - Non-Dual and/or Pre-65	4.4%	2.5%	**2.5%**
LTSS - Intellectual Disability	3.7%	2.6%	**2.6%**
LTSS - Children's Mental Health	4.4%	4.7%	**4.4%**

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:

Not applicable, there are no incentives within the waiver renewal.

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**.

The costs reported for R1 and R2 in Appendix D3 and Appendix D5 come from the historical CMS-64.9 forms which contain capitation costs net of pharmacy rebates for each MEG. However, within FFY19 Q4 of the R2 base period, the reported pharmacy rebates are double the typical amounts reported due to prior period adjustments associated with reporting CMS-64s on a paid basis. In order to account for the levels of pharmacy rebates that are anticipated throughout the waiver projection period, an adjustment was made in Appendix D5 to align the collection of pharmacy rebates with typical levels expected throughout the waiver renewal period ($90M-$100M quarterly). A MEG-specific pharmacy rebate adjustment was made

in the P1 projection period to align with typical levels of rebate collection. If this adjustment were not made the projected medical costs would be understated as a result of the increased pharmacy rebates reported within the R2 base period. Further details can be found in Section D, Part 1.F above.

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

Please note, due to the Iowa waiver submission being on a five year basis, the amounts shown for P1 and P2 from the prior waiver submission (in columns K-P) have been adjusted to reflect a blend of P3 and P4 from the prior waiver submission in order to align with the R1 and R2 time periods used as the basis of the waiver renewal. R1 and R2 in the waiver renewal are SFY19 and SFY20 (through March 31, 2020) so the PMPMs corresponding to those time periods were pulled from the prior waiver submission. This adjustment ensures that everything is on the same basis when determining historical cost-effectiveness for the five year waiver submission.

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**:

Membership projections to P1 are estimated by applying the quarterly growth from the average quarterly enrollment in R2 (July 1, 2019 – March 31, 2020) to the first quarter of P1 (April 1, 2021 – June 30, 2021). The following table shows the quarterly increase of membership that was used within Appendix D to capture anticipated enrollment changes throughout the waiver projection period:

MEG	Quarterly Growth %
TANF	0.50%
Expansion	0.50%
Family Planning	0.50%
Aged/Blind/Disabled Non-Dual	0.50%
Aged/Blind/Disabled Dual	0.50%
LTSS - Elderly	0.25%
LTSS - Non-Dual and/or Pre-65	0.25%

LTSS - Intellectual Disability	0.25%
LTSS - Children's Mental Health	0.25%

The member month projections are based on the average growth of historical Iowa Health Link experience for each 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**:

In order to calculate the State Plan Inflation Adjustment PMPM for P1, the 3.4% annual aggregate trend is applied from the midpoint of the R2 period (July 1, 2019 – March 31, 2020) to the midpoint of P1 (April 1, 2021 – March 31, 2022). The State Plan annual trends vary by MEG but are consistent across all five years of the waiver projection and result in a 3.4% annual trend for P1 and a 3.5% annual trend in P2-P5.

The annual trends developed during the IA Health Link managed care capitation rate setting process were used as the basis for trending the cost of services covered under the waiver from the R2 experience period forward to P1-P5. The rating trends inherent in the capitation rates for State Plan Services, 1915(b)(3) Services, and 1915(c) Services serve as the basis for the actual trend rates used to project the R2 experience forward through P5. In general, trend development in the capitation rate setting process utilizes 3, 6, and 12 month moving averages (MMA) when analyzing the course of the historical SFY18-SFY20 YTD IA Health Link experience, but there is no predetermined algorithm used for all populations and services.

The 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service experience and the State Plan Service trend. In aggregate, the 1915(b)(3) Service trend is 3.9% annual, while the State Plan Service trend is 3.4%. However, the 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service trends and State Plan Services trends and this difference is just due to the differences in service mix between the MEGs. The following table shows the annual trends for the 1915(b)(3) and State Plan Services and the lesser of 1915(b)(3) trend that was used to populate Appendix D5.

	Annual PMPM Trends		
MEG	**1915(b)(3)**	**State Plan**	**Final 1915(b)(3) Used**
TANF	3.7%	4.0%	**3.7%**
Expansion	4.8%	4.6%	**4.6%**
Aged/Blind/Disabled Non-Dual	4.9%	4.2%	**4.2%**

Aged/Blind/Disabled Dual	3.7%	2.7%	**2.7%**
LTSS - Elderly	3.7%	1.5%	**1.5%**
LTSS - Non-Dual and/or Pre-65	4.4%	2.5%	**2.5%**
LTSS - Intellectual Disability	3.7%	2.6%	**2.6%**
LTSS - Children's Mental Health	4.4%	4.7%	**4.4%**

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**:

   In order to calculate the State Plan Inflation Adjustment PMPM for P1, the 3.4% annual aggregate trend is applied from the midpoint of the R2 period (July 1, 2019 – March 31, 2020) to the midpoint of P1 (April 1, 2021 – March 31, 2022). The State Plan annual trends vary by MEG but are consistent across all five years of the waiver projection and result in a 3.4% annual trend for P1 and a 3.5% annual trend in P2-P5.

   The annual trends developed during the IA Health Link managed care capitation rate setting process were used as the basis for trending the cost of services covered under the waiver from the R2 experience period forward to P1-P5. The rating trends inherent in the capitation rates for State Plan Services, 1915(b)(3) Services, and 1915(c) Services serve as the basis for the actual trend rates used to project the R2 experience forward through P5. In general, trend development in the capitation rate setting process utilizes 3, 6, and 12 month moving averages (MMA) when analyzing the course of the historical SFY18-SFY20 YTD IA Health Link experience, but there is no predetermined algorithm used for all populations and services.

   The 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service experience and the State Plan Service trend. In aggregate, the 1915(b)(3) Service trend is 3.9% annual, while the State Plan Service trend is 3.4%. However, the 1915(b)(3) Service trends for each MEG have been limited to the lesser of the 1915(b)(3) Service trends and State Plan Services trends and this difference is just due to the differences in service mix between the MEGs. The following table shows the annual trends for the 1915(b)(3) and State Plan Services and the lesser of 1915(b)(3) trend that was used to populate Appendix D5.

	Annual PMPM Trends		
MEG	**1915(b)(3)**	**State Plan**	**Final 1915(b)(3) Used**
TANF	3.7%	4.0%	**3.7%**
Expansion	4.8%	4.6%	**4.6%**
Aged/Blind/Disabled Non-Dual	4.9%	4.2%	**4.2%**

Aged/Blind/Disabled Dual	3.7%	2.7%	**2.7%**
LTSS - Elderly	3.7%	1.5%	**1.5%**
LTSS - Non-Dual and/or Pre-65	4.4%	2.5%	**2.5%**
LTSS - Intellectual Disability	3.7%	2.6%	**2.6%**
LTSS - Children's Mental Health	4.4%	4.7%	**4.4%**

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

Not applicable.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.