Section 1915(b) Waiver
Proposal for MCO, PIHP, PAHP, PCCM Programs
& FFS Selective Contracting Programs

The Iowa High Quality Healthcare Initiative

State of Iowa
Department of Human Services

September 3, 2015

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Facesheet:

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

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

The name of the waiver program is the **Iowa High Quality Healthcare Initiative**.

Type of request: This is an

X Initial request for new waiver. All sections are filled.

__ Amendment request for existing waiver, which modifies Section/Part __.
- __ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
- __ Document is replaced in full, with changes highlighted

__ Renewal request
- __ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
- __ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is:
- __ Replaced in full
- __ Carried over from previous waiver period.

The State:
- __ Assures there are no changes in the Program Description from the previous waiver period.
- __ Assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is:
- __ Replaced in full
- __ Carried over from previous waiver period.

The State:
- __ Assures there are no changes in the Monitoring Plan from the previous waiver period.
- __ Assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates:

This waiver is requested for a period of 5 years; effective **April 1, 2016** and ending **March 31, 2021**.

State Contact:

The State contact person for this waiver is **Mikki Stier, Medicaid Director** and can be reached by telephone at **515-256-4621**, fax at **515-725-1360**, or e-mail at **mstier@dhs.state.ia.us**.

Section A: Program Description

Part I: Program Overview

Tribal Consultation

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

The Iowa Medicaid Enterprise (IME) consulted with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of this waiver request. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. This notice was provided July 14, 2015 and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions.

Only one question was received asking whether I/T/U providers would be required to enroll with an MCO in order to receive reimbursement for services rendered to American Indian/Alaska Natives (AI/AN) who opt to enroll in managed care through the Initiative. The State informed this provider that he/she, whether participating in the network or not, will be paid for covered Medicaid or CHIP managed care services provided to AI/AN enrollees who are eligible to receive services either: (1) at a rate negotiated between the managed care entity and the provider; or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. Further, the State will operate in compliance with the provisions of the American Recovery and Reinvestment Act and CMS guidance.

Program History

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

Iowa Department of Human Services (DHS) has continually sought to improve Medicaid and the Children's Health Insurance Program (CHIP), and beneficiary choice, accountability, quality of care, and health outcomes. DHS has also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative).

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series

of public meetings. Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. Several amendments to the RFP have been released incorporating changes based on stakeholder feedback. Additional opportunity to comment on the Initiative and its corresponding waivers will be obtained through a formal public notice and comment period.

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). The Initiative goals include:

1. Creation of a single system of care that delivers efficient, coordinated, health care and promotes accountability in health care coordination;
2. Improvement in the quality of care and health outcomes for members;
3. Integration of care across the health care delivery system;
4. Emphasis of member choice and increased access to care;
5. Increased program efficiencies and budget accountability;
6. Continued rebalancing efforts to provide community-based rather than institutional care, when appropriate;
7. Holding MCOs responsible for outcomes.

MCOs will be responsible for delivering all Medicaid covered benefits, with the exception of dental benefits. MCOs will deliver physical health, behavioral health, and long-term services and supports in a highly coordinated manner. Excluded populations will continue to receive services through the fee-for-service delivery system outlined in the Medicaid State Plan.

Statewide MCO enrollment in the Initiative will be effective April 1, 2016. The State will begin accepting MCO selections from current Medicaid members beginning in fall 2015. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights. To facilitate the MCO selection process, members will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to:

1. Distribute the population evenly among the MCOs; and
2. Assign all members of a particular family to the same MCO.

As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-member relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To allow additional time and assistance for members receiving

long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915(i) habilitation services under the Iowa Medicaid State Plan. The Enrollment Broker will take MCO selections and provide choice counseling to assist members in selecting an MCO. Members will be fully enrolled based on their tentative assignment if alternative choice is not made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first ninety days of enrollment without cause.

A. Statutory Authority

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

   a. **X** 1915(b)(1) – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

   b. __ 1915(b)(2) – A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

   c. **X** 1915(b)(3) – The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

   d. **X** 1915(b)(4) – The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards, which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

      X MCO
      __ PIHP
      __ PAHP
      __ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that

requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
__ FFS Selective Contracting program (please describe):

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

   a. __ 1902(a)(1) Statewideness—This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

   b. **X** 1902(a)(10)(B) Comparability of Services—This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

   c. **X** 1902(a)(23) Freedom of Choice—This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

   d. __ 1902(a)(4) To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

   e. Other Statutes and Relevant Regulations Waived (Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.)

B. Delivery Systems

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

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

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

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

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

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

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

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

__ the same as stipulated in the state plan
__ is different than stipulated in the state plan (please describe):

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

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

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

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

1. Assurances.

   X The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
   __ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

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

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

3. Rural Exception.

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

4. 1915(b)(4) Selective Contracting

__ Beneficiaries will be limited to a single provider in their service area (please define service area).
X Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

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

X Statewide—all counties, zip codes, or regions of the State
__ Less than Statewide

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Adair, Adams, Allamakee, Appanoose, Audubon, Benton, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Carroll, Cass, Cedar, Cerro, Gordo, Cherokee, Chickasaw, Clarke, Clay, Clayton, Clinton, Crawford, Dallas, Davis, Decatur, Delaware, Des Moines, Dickinson, Dubuque, Emmet, Fayette, Floyd, Franklin, Fremont, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Harrison, Henry, Howard, Humboldt, Ida, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Kossuth, Lee, Linn, Louisa, Lucas, Lyon, Madison, Mahaska, Marion, Marshall, Mills, Mitchell, Monona, Monroe, Montgomery, Muscatine,	MCO	• Amerigroup Iowa, Inc. • AmeriHealth Caritas Iowa, Inc. • UnitedHealthcare Plan of the River Valley, Inc.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
O'Brien, Osceola, Page, Palo Alto, Plymouth, Pocahontas, Polk, Pottawattamie, Poweshiek, Ringgold, Sac, Scott, Shelby, Sioux, Story, Tama, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Webster, Winnebago, Winneshiek, Woodbury, Worth, Wright		

E. Populations Included in Waiver

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

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

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

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

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

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

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

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

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

The following §1915(c) and §1115 Demonstration groups will also be included in the waiver program:

§1915(c) HCBS Physical Disability Waiver Enrollees
§1915(c) HCBS Health and Disability Waiver Enrollees
§1915(c) HCBS Children's Mental Health Waiver Enrollees
§1915(c) HCBS Elderly Waiver Enrollees
§1915(c) HCBS Intellectual Disabilities Waiver Enrollees
§1915(c) HCBS AIDS Waiver Enrollees
§1915(c) HCBS Brain Injury Waiver Enrollees
§1115 Iowa Family Planning Demonstration Enrollees
§1115 Iowa Wellness Plan Demonstration Enrollees

All other Iowa Medicaid State Plan populations, not specifically excluded in below, shall be included in the waiver program.

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

__ Medicare Dual Eligible—Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
__ Poverty Level Pregnant Women—Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
__ Other Insurance—Medicaid beneficiaries who have other health insurance.
__ Reside in Nursing Facility or ICF/MR—Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

__ Enrolled in Another Managed Care Program—Medicaid beneficiaries who are enrolled in another Medicaid managed care program.
__ Eligibility Less Than 3 Months—Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
__ Participate in HCBS Waiver—Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
__ American Indian/Alaskan Native—Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
__ Special Needs Children (State Defined) —Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
__ SCHIP Title XXI Children—Medicaid beneficiaries who receive services through the SCHIP program.
X Retroactive Eligibility—Medicaid beneficiaries for the period of retroactive eligibility.
X Other (Please define): **Nonqualified immigrants receiving time-limited coverage of certain emergency medical conditions; persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage; persons enrolled in the Health Insurance Premium Payment program; persons who are medically needy; and persons eligible only for the Medicare Savings Program will be excluded from participating in the Waiver Program. Note: American Indian/Alaskan Native (AI/AN) populations shall be enrolled voluntarily.**

F. Services

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

1. Assurances.

X The State assures CMS that services under the Waiver Program will comply with the following federal requirements: services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2); access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114; and access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)
__ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).
X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts

that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program: (1) 1902(s) adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility; (2) Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC; (3) Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries; (4) Section 1902(a)(4)(C) freedom of choice of family planning providers; and (5) Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

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

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

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

   X MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.
   __ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
   __ The State will pay for all family planning services, whether provided by network or out-of-network providers.
   __ Other (please explain):
   __ Family planning services are not included under the waiver.

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

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

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

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

5. EPSDT Requirements.

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

6. 1915(b)(3) Services.

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

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Intensive Psychiatric Rehabilitation	Rehabilitation and Support Services are comprehensive outpatient services based in the individual's home or residence and/or community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persisting mental disorders, and/or complex symptoms who require multiple mental health and psychosocial support services. Such services are active and rehabilitative in focus, and are initiated and continued when there is a reasonable likelihood that such services will lead to specific observable improvements in the individual's functioning.	Community Mental Health Centers (CMHCs), other agencies providing mental health services, and accredited organizations under Iowa Administrative Code Chapter 24.	No	Medicaid Eligible Persons Age 18 or Older	Statewide	Negotiated Rates

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Community Support	Required Service: Community Support Services (CSS) are provided to adults with a severe and persistent mental illness. These services are designed to support individuals as they live and work in the community. These services address mental and functional disabilities that negatively affect integration and stability in the community. CSS staff attempt to reduce or manage symptoms/reduced functioning that result from a mental illness. CSS providers are expected to have knowledge and experience in working with this population. Staff should have the ability to create relationships with this population that provide a balance between support of the mental illness and allow for maximum individual independence. Community support program components include: (1) monitoring of mental health symptoms and functioning/reality orientation; (2) transportation; (3) supportive relationship; (4) communication with other providers; (5) ensuring consumer attends appointments/obtains medications; (6) crisis intervention/developing crisis plan; and (7) coordination and development of natural support systems for mental health support.	Community Mental Health Centers (CMHCs) and accredited organizations under Iowa Administrative Code Chapter 24.	No	Medicaid Eligible Persons Age 18 or Older	Statewide	Negotiated Rates

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Peer Support	Peer Support and Parent Peer Support services. The services provided to Eligible Persons by other mental health consumers who are specifically trained to provide peer support services. Services are targeted toward the support of persons with a serious and persistent mental illness or substance abuse. Peer support services focus on individual support and counseling from the perspective of a trained peer, and may also include service coordination and advocacy activities as well as rehabilitative services. Peer support services are initiated when there is a reasonable likelihood that such services will benefit an Eligible Person's functioning and assist him or her in maintaining community tenure.	Peer Support Specialists at accredited organizations contracted using MCO credentialing standards and Peer Support Specialist has received Georgia Model training.	No	Medicaid Eligible Persons Age 18 or Older. Parent Peer Support is to provide support to the parents of children or adolescents.	Statewide	Negotiated Rates
Residential Substance Abuse Treatment	See below – to III.1, III.3 & III.5					

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Integrated Services and Supports (Wrap-around Services)	Informal services/supports that are offered by providers, family/friends and other members of the natural support community. The services/supports must be integrated into the treatment plan. These interventions help individuals to remain in or return to their home and limit the need for more intensive out-of home mental health treatment. Integrated services and supports are specifically tailored to an individual consumer's needs at a particular point in time, and are not a set menu of services. A joint treatment planning process may identify the need for integrated services/supports. The consumer/family member must lead the planning process and other members of the team giving their input as well. Individual contacts with the consumer/family may also identify the need. Ideally this provides more flexibility to provide consumers unique services to address the mental health needs to augment and complement those provided through other funders and systems. There is natural support involvement that may require reimbursement and at other times be part of the family process. Examples include: peer mentor, family support person, transportation for treatment, hotel for parent to attend treatment of child.	Entire provider network contracted using MCO credentialing standards.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Respite	Required Service: In/Out of Home Respite are community and home-based services that can be provided in a variety of settings. Respite care is a brief period of rest and support for individuals and/or families. Respite care is intended to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current problems/issues related to a mental health diagnosis. Respite may be provided for up to 72 hours and can be planned or in response to a crisis. A comprehensive respite program must provide or ensure linkages to a variety of residential alternatives for stabilizing and maintaining consumers who require short-term respite in a safe, secure environment with twenty four hour supervision outside a hospital setting. Respite is a community-based alternative to inpatient hospitalization that provides a temporary, safe, and secure environment with a flexible level of supervision and structure. These services are designed to divert individuals from an acute hospitalization to a safe environment where monitoring of medical and psychiatric symptoms can occur.	Hospitals, agencies, CMHCs contracted using MCO credentialing standards and holding national accreditation (JCAHO, CARF, COA, AOA, or AAAHC) or under Iowa Administrative Code Chapter 24.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Level III.1. Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Abuse	From ASAM Patient Placement Criteria: Level III services offer organized treatment services that feature a planned regimen of care in a 24 hour residential setting. All Level III programs serve individuals who, because of their specific functional deficits, need a safe and stable environment in order to develop their recovery skills. The sublevels within Level III exist on a continuum ranging from the least intensive to the most intensive medically monitored intensive inpatient services. The term "clinically managed" (Levels 1-3 have relatively stable problems in Axis I and/or less stable problems in Axis II of the DSM. Level III.1 – at least 5 hours/week of treatment plus the structured recovery environment.	Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates
Level III.3 & III.5 Clinically Managed Medium/ High Intensity Residential Treatment Substance Abuse	Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 are designed to treat persons who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7.	Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates

Service	Description of Service	Provider Type/ Qualifications	Duplicative of other Medicaid State Plan Service	Populations Eligible	Geographic Availability	Reimbursement Method
Level III.3 & 5 Clinically Managed Medium/ High Intensity Residential Treatment Substance Abuse Hospital Based	Structured recovery environment in combination with clinical services. Functional deficits seen in individuals are primarily cognitive and based on a behavioral assessment (Level III.3). Level III.5 are designed to treat persons who have significant social and psychological problems. Services are based on a therapeutic treatment community. A step-down or alternative to Level III.7.	Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates
Level III.7 Substance Abuse Residential Community-based	24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment in a licensed substance abuse facility	Substance Abuse programs licensed by Iowa Department of Public Health under Iowa Code Chapter 125.	No	Medicaid Eligible Persons	Statewide	Negotiated Rates

7. Self-referrals.

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

***Emergency Services* – In accordance with 42 CFR 422.113, the MCO shall provide members with access to emergency services without requiring prior authorization or primary care physician referral, regardless of whether these services are provided by a contract or non-contract provider. Post-stabilization services will be provided consistent with 42 CFR 422.113(c)(2).**

***Family Planning Services* – In accordance with 42 CFR 431.51(b)(2), the MCO shall provide members with access to providers of family planning services without requiring prior authorization or primary care physician referral, regardless of whether these services are provided by a contract or non-contract provider.**

***Women's Health* – In accordance with 42 CFR 438.206(b)(2), the MCO shall provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.**

***Post-Partum Hospital Stays* – The MCO shall not require a provider to obtain prior authorization for post-partum hospital stays up to forty- eight (48) hours for normal vaginal deliveries or ninety-six (96) hours following a cesarean section.**

***EPSDT* – The MCO shall provide members with access EPSDT screening services without prior authorization or a primary care physician referral.**

***Behavioral Health* – The MCO shall provide members with access to behavioral health providers without a primary care physician referral.**

***Program Implementation Continuity of Care Provisions:* The MCOs shall permit members to self-refer to out-of-network providers during initial program implementation. Specifically, members may continue out-of-network form their current LTSS residential provider for 1 year, and all other provider types (e.g., behavioral health, physical health, pharmacy, home health) for 90 days without a referral required.**

Part II: Access

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

A. Timely Access Standards

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

   X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
   __ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
   X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

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

      __ PCPs (please describe):
      __ Specialists (please describe):
      __ Ancillary providers (please describe):
      __ Dental (please describe):
      __ Hospitals (please describe):
      __ Mental Health (please describe):
      __ Pharmacies (please describe):
      __ Substance Abuse Treatment Providers (please describe):
      __ Other providers (please describe):

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

__ PCPs (please describe):
__ Specialists (please describe):
__ Ancillary providers (please describe):
__ Dental (please describe):
__ Mental Health (please describe):
__ Substance Abuse Treatment Providers (please describe):
__ Urgent care (please describe):
__ Other providers (please describe):

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

__ PCPs (please describe):
__ Specialists (please describe):
__ Ancillary providers (please describe):
__ Dental (please describe):
__ Mental Health (please describe):
__ Substance Abuse Treatment Providers (please describe):
__ Other providers (please describe):

d. __ Other Access Standards (please describe):

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

B. Capacity Standards

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

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the

State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

   a. __ The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

   b. __ The State ensures that there are adequate number of PCCM PCPs with open panels. Please describe the State's standard.

   c. __ The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

   d. __ The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

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

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

   e. __ The State ensures adequate geographic distribution of PCCMs. Please describe the State's standard.

f. __ PCP: Enrollee Ratio. The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

g. __ Other capacity standards (please describe):

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

C. Coordination and Continuity of Care Standards

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

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs. The following items are required.

a. __ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. **X** Identification. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

MCOs are responsible for conducting a health risk screening for every enrolled member (within ninety (90) days of enrollment for new members). The screening is designed to identify a member's physical, behavioral, social, functional and psychological status and needs, using a tool that complies with National Committee for Quality Assurance (NCQA) standards for health risk screenings and contains questions tied to social determinants of health. During the initial health risk screening, members are offered assistance in arranging a visit with their primary care physician for preventive services, a baseline medical assessment, and screening for potential risk of specific diseases or conditions. In addition MCOs utilize industry standard predictive modeling, claims review, member and caregiver requests and physician referrals to identify persons with special health care needs.

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

Following the health screening noted above, MCOs are responsible for conducting a comprehensive health assessment when a member is identified as having a special health care need, or when there is a need to follow-up on problem areas. The assessment incorporates a review of the member's claims history, contact with the member and his/her family, caregivers or representative and health care providers, and includes an evaluation of a member's need for assignment to a health home.

d. **X** Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

- **X** Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
- **X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
- **X** In accord with any applicable State quality assurance and utilization review standards.

Following the identification and assessment noted above, MCOs utilize risk stratification levels to determine the intensity and frequency of follow-up care required for each member. A plan is developed by the MCO to coordinate care according to the individual member's needs and is developed in consultation with a multidisciplinary team of qualified health care

professionals, members, their families and/or advocates and caregivers, and others chosen by the member. MCOs are responsible for developing plans that reflect the cultural considerations of the member, and the plan development process must be conducted in plain language, and must be accessible to members with disabilities and/or limited English proficiency. MCOs are also required to communicate the plan to members' primary care physician or other significant providers.

e. **X** Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

In accordance with 42 CFR 438.208(c), MCOs are required to provide members with special needs who are determined to need a course of treatment or regular care monitoring with direct access specialist treatment through an established mechanism (e.g., standing referral form the member's PCP, approved number of visits).

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

a. __ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.

b. __ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. __ Each enrollee is receives health education/promotion information. Please explain.

d. __ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.

e. __ There is appropriate and confidential exchange of information among providers.

f. __ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.

g. __ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. __ Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. __ Referrals: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Part III: Quality

1. Assurances for MCO or PIHP programs.

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on: **The State's current MCO quality strategy is submitted annually in July. The State will submit a revised quality strategy that includes the waiver by December 31, 2015.**

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

Program	Name of Organization	Activities Conducted		
		EQR Study	Mandatory Activities	Optional Activities
MCO	The State is in the process of procuring an EQRO	X	X	To be determined through procurement process

2. Assurances For PAHP program.

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

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

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

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

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

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

__ Provide education and informal mailings to beneficiaries and PCCMs;
__ Initiate telephone and/or mail inquiries and follow-up;
__ Request PCCM's response to identified problems;
__ Refer to program staff for further investigation;
__ Send warning letters to PCCMs;
__ Refer to State's medical staff for investigation;
__ Institute corrective action plans and follow-up;
__ Change an enrollee's PCCM;
__ Institute a restriction on the types of enrollees;
__ Further limit the number of assignments;
__ Ban new assignments;
__ Transfer some or all assignments to different PCCMs;
__ Suspend or terminate PCCM agreement;
__ Suspend or terminate as Medicaid providers; and
__ Other (explain):

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

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

__ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
__ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
__ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
  __ Initial credentialing
  __ Performance measures, including those obtained through the following (check all that apply):
    __ The utilization management system.
    __ The complaint and appeals system.
    __ Enrollee surveys.
    __ Other (please describe):
__ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
__ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
__ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
__ Other (please describe):

d. __ Other quality standards (please describe):

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

Part IV: Program Operations

A. Marketing

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

1. Assurances

X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

2. Details

a. Scope of Marketing

__ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

X The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

MCOs are encouraged to market to the general community and potential enrollees, while complying with all applicable laws and regulations regarding marketing by health insurance issuers. All marketing materials must be distributed to the MCO's entire service area and shall comply with the information requirements at 42 CFR 438.10. MCOs may conduct both indirect and direct marketing. Permitted indirect marketing activities include mass

media advertising such as radio, television and billboards, while permitted direct marketing activities include direct mail and participation in community oriented marketing (i.e., community health fairs). MCOs are not permitted to directly or indirectly engage in door-to-door, telephone or other cold-call marketing activities.

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

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

MCOs are encouraged to participate in community oriented marketing (i.e., community health fairs). Tokens or gifts of nominal value may be distributed at such events to potential enrollees. MCOs are subject to penalties under the Social Security Act §1128(a)(5) regarding inducements, remunerations, and gifts to Medicaid recipients, and must comply with all marketing provisions in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements. The State monitors MCO activities by requiring approval of all marketing materials and plans prior to distribution.

__ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent.

X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

MCOs are required to provide all written materials in English and Spanish, and any additional prevalent languages identified by the State in the future. Per 42 CFR 438.204, at the time of enrollment with the MCO, the State shall provide the primary language of each enrollee. MCOs shall utilize this information to ensure communication materials are distributed in the appropriate language. MCOs shall also identify additional languages that are prevalent among the MCOs membership. Written information must be provided in any such prevalent languages identified by the MCOs. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.

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

__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

X The languages comprise all languages in the service area spoken by approximately **5%** percent or more of the population.
__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
__ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
__ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages

X Potential enrollee and enrollee materials will be translated into the prevalent non-English languages listed below (If the State does not require written materials to be translated, please explain): **Materials will be translated into Spanish and any additional prevalent languages identified by the State. MCOs shall also identify additional languages that are prevalent among the MCOs membership.**

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

__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
X The languages spoken by approximately **5%** percent or more of the potential enrollee/ enrollee population.
__ Other (please explain):

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

MCOs are required to make oral interpretation services available free of charge to each member. This applies to all non-English languages, and is not limited to prevalent languages. MCOs must notify all members that oral interpretation is available and how to access those services. The Enrollment Broker provides oral translation services to potential enrollees.

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

The State utilizes websites, the Enrollment Broker, MCO helplines and Iowa Department of Human Services (DHS) offices to educate enrollees and potential enrollees on managed care.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

__ State
X Contractor (please specify): **Enrollment Broker**
__ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

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

__ the State
X State contractor (please specify): **DHS currently contracts with Maximus for Enrollment Broker services. In accordance with 42 CFR 438.810, the Enrollment Broker is independent of any MCO, PIHP, PAHP, PCCM or other health care provider in Iowa, and is free from conflict of interest. The State's current contract with Maximus (MED-10-001-A) was approved by CMS on April 8, 2010. Maximus will also be providing Enrollment Broker services for the High Quality Healthcare Initiative, including providing enrollment activities and choice counseling. DHS is in the process of amending its current contract for managed care transition activities, and will be sending to CMS for approval by September 1, 2015.**

X the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

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

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

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

      Education and outreach efforts regarding the managed care program to potential enrollees is primarily maintained by the Enrollment Broker through written materials and oral communications. The Enrollment Broker is available to provide information about the basic features of the program and information specific to each contractor operating in the potential enrollee's service area.

      Providers are informed of the Initiative through a variety of strategies. For example, the State maintains a website through which information on all Iowa Medicaid Enterprise (IME) programs, including the Iowa High Quality Healthcare Initiative is provided. Information is also provided via technical and instructional manuals, provider manuals, informational/policy update letters, online provider portals, and training sessions. The Department has developed a comprehensive outreach and education plan for the transition to managed care, to guide all communications with members, providers, stakeholders and the general public. The plan includes strategies and tactics to support the communication needs of individual groups.

      Other interested parties, such as advocates and provider associations, were engaged during the development of the Initiative through a series of statewide

public meetings—Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City and Sioux City. In total, close to 1,000 people attended the meetings in person or via phone and provided the State with valuable comments and questions. In addition, stakeholders and the public were requested to submit questions and comments directly to the State via email. During the implementation phase of the Initiative, these relationships will continue to be leveraged.

The public has also had the opportunity to comment on this waiver application through a public notice and comment process. Public notice was provided on July 20, 2015. This notice, waiver documents, and information about the Iowa High Quality Healthcare Initiative were posted on a website dedicated to the Initiative and non-electronic copies were made available for review at DHS Field Offices. In addition, a summary notice was published in several newspapers with statewide circulation. The notice provided the option for any individual to submit written feedback to the State by email or by USPS mail. Comments were accepted electronically through a dedicated email address and a physical address was provided for written comments to be submitted by mail or in person.

In addition, the State held four public hearings to offer an opportunity for the public to provide written or verbal comments about the waiver. Hearings were held on July 27, 2015 (Bettendorf, IA), July 31, 2015 (Des Moines, IA), August 3, 2015 (Cedar Rapids, IA), and August 5, 2015 (Sioux City, IA). Toll free conference call capabilities were made available for the August 3rd and 5th dates in order to accommodate interested parties who were unable to attend a hearing in person. Hearings followed the same format, beginning with a brief presentation by State staff about the Initiative, a short question and answer session, and at least one hour of public comments. Time permitting, State staff fielded additional questions at the end of the hearing. The public comment period ended on August 24, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Throughout the public comment period, a total of 162 questions and comments were received (51 questions, 42 verbal comments, and 69 written comments). Very few comments were waiver specific, as the vast majority were aimed at the Initiative in general. Of these questions and comments, a broad range of topics were addressed including eligibility/included benefits, member choice, MCO standardization, quality/safety, enrollment, outreach, reimbursement, provider issues, MCO oversight/evaluation, implementation timeline, case management, home and community based services, and service delivery/access. A summary of these comments and State Responses can be found online at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

b. Administration of Enrollment Process.

__ State staff conducts the enrollment process.

X The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
X The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: **Maximus**

Please list the functions that the contractor will perform:

X choice counseling
X enrollment
X other (please describe): **The Enrollment Broker also administers a Healthy Behaviors program and fee-for-service functions prior to a member's enrollment with an MCO. The Healthy Behaviors program will continue to be administered by IME in the manner previously approved by CMS. Iowa Medicaid Healthy Behaviors Program and Premium Monitoring Protocols for Year 2 are part of both the Iowa Wellness Plan Waiver Amendment Special Terms and Conditions-Corrected and the Iowa Marketplace Choice Plan Waiver Amendment Special Terms and Conditions- Corrected. The waivers are available at the links below:**

http://dhs.iowa.gov/sites/default/files/WellnessSTCsTechnicalCorrections_020215.pdf

http://dhs.iowa.gov/sites/default/files/MarketplaceChoiceSTCsTechnicalCorrections_02022015.pdf

The Enrollment Broker will continue the function of educating members, providers and stakeholders about the Healthy Behaviors program. The Enrollment Broker will also continue the function of notifying members who become subject to premiums if they do not complete their healthy behaviors. More information about the healthy behaviors program is available at: http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan/healthybehaviorsprogram.

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

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

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

Statewide MCO enrollment in the Initiative will be effective April 1, 2016. As such, the State will begin accepting MCO selections from current Medicaid enrollees beginning in fall 2015. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) distribute the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The Enrollment Broker will take MCO selections and provide choice counseling to assist enrollees. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause.

The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To permit additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915(i) home and community based services under the Iowa Medicaid State Plan.

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

X If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

- **X** Potential enrollees will have **10 to 45 days** days/month(s) to choose a plan.
- **X** Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

After the initial waiver implementation, upon receiving a new Medicaid eligibility determination, the Enrollment Broker will send the member information about each MCO available. In accordance with Iowa Administrative Code, the member will have a minimum of 10 days to make an MCO selection. Members will have a maximum of 45 days to make a

selection. An individual's maximum timeframe for selection will be based on the date of his or her Medicaid eligibility notice. This is because the 25th day of the month is the cut-off date for MCO assignments to be effective the 1st of the following month. Any MCO selections made after the 25th of a month will be effective the first day of the second following month. The member will have 10 to 45 days to select the MCO of their choice. If the member does not make a choice, the IME will auto-assign the member to an MCO. Members will be auto-assigned to each MCO on an alternating basis.

The State automatically enrolls beneficiaries

__ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

__ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1):

__ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:

__ The State provides guaranteed eligibility of [X] months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

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

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

d. Disenrollment:

X The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

__ Enrollee submits request to State.

__ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

X Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

X The State has a lock-in period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of **12** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

For purposes of disenrollment, "cause" includes: (1) member moves out of the service area; (2) MCO does not, because of moral or religious objections, cover the services the member seeks; (3) the member needs related services to be performed at the same time, and not all related services are available within the network and the member's provider determines that receiving the services separately would subject the member to unnecessary risk; (4) when a provider disenrolls from the MCO and this termination would result in disruption to the member's residence or employment; or (5) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

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

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

- **X** MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons: **The MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees. The MCO must provide evidence to the State that this condition has been met. Further, the MCO is required to have methods by which the State is assured that disenrollment is not requested for another reason. The State retains sole authority for determining if this condition has been met and disenrollment will be approved.**
- **X** The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

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

D. Enrollee rights.

1. Assurances.

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

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

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

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

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

E. Grievance System

1. Assurances for All Programs. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including: informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action, ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

3. Details for MCO or PIHP programs.

   a. Direct access to fair hearing.

      X The State requires enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

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

   b. Timeframes

      X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an appeal is **30** days (between 20 and 90).

      X The State's timeframe within which an enrollee must file a grievance is **No Limit** days.

   c. Special Needs

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

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

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

   __ The grievance procedures is operated by:

      __ the State

      __ the State's contractor (please identify):

__ the PCCM
__ the PAHP.

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

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

__ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: **[X]** (please specify for each type of request for review)

__ Has time frames for resolving requests for review. Specify the time period set: **[X]** (please specify for each type of request for review)

__ Establishes and maintains an expedited review process for the following reasons: [**X]**. Specify the time frame set by the State for this process **[X]**.

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

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

__ Other (please explain):

F. Program Integrity

1. Assurances.

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with: an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above. The prohibited relationships are: (1) a director, officer, or partner of the MCO, PCCM, PIHP, or PAHP; (2) a person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity; a person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that: could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual; has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act; employs or contracts directly or indirectly with an individual or entity that is precluded from furnishing health care, utilization review, medical social services, or administrative

services pursuant to section 1128 or 1128A of the Act, or could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

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

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint: (1) program Impact (Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems); (2) access (Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care); and (3) quality (Coverage and Authorization, Provider Selection, Quality of Care).

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

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

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

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

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

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

Part I: Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored. Please note: (1) MCO, PIHP, and PAHP programs—there must be at least one checkmark in each column; and (2) PCCM and FFS selective contracting programs—there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality." If this waiver authorizes multiple programs, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation	X				X	X	X	X	X	X	X	X
Consumer Self-Report data	X				X		X		X		X	X
Data Analysis (non-claims)			X	X		X				X		X
Enrollee Hotlines					X							
Focused Studies												
Geographic mapping	X							X				
Independent Assessment	X					X	X	X	X	X	X	X
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy Assurance by Plan	X											
Ombudsman			X			X			X	X		X
On-Site Review	X	X	X	X	X	X	X	X	X	X	X	X
Performance	X		X	X		X	X	X	X	X	X	X

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Improvement Projects												
Performance Measures	X		X	X		X	X	X	X	X	X	X
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability							X					
Utilization Review						X			X	X		
Other		Desk Review		Work Plan	Desk Review							

Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why. For each activity, the state must provide the following information: applicable programs (if this waiver authorizes more than one type of managed care program), personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor), detailed description of activity, frequency of use, and how it yields information about the area(s) being monitored.

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

   __ NCQA
   __ JCAHO
   __ AAAHC
   __ Other (please describe):

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

   X NCQA
   __ JCAHO
   __ AAAHC
   X Other (please describe):

   MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). If not already accredited, MCOs must demonstrate initiation of the accreditation process as of the effective date of contracting with the State. MCOs must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract with the State.

c. Consumer Self-Report data

   X CAHPS (please identify which one(s)): **Adult and Child Medicaid Surveys**
   __ State-developed survey
   __ Disenrollment survey
   __ Consumer/beneficiary focus groups

MCOs are required to provide to the State annually the survey results from its independent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey is used to assess and document the experiences members report with their MCO as an indicator of quality of various aspects of care and customer service. The CAHPS survey is used to monitor information to beneficiaries, timely access, PCP/specialist capacity, coordination/continuity, provider selection and quality of care.

State staff review the CAHPS survey results and any problems, issues, or discrepancies identified are acted upon promptly. In the event of identified deficiencies, a corrective action plan or other contractually agreed upon remedy is required. Additionally, this information is utilized to identify issues for performance improvement projects.

d. Data Analysis (non-claims)

__ Denials of referral requests
X Disenrollment requests by enrollee
  X From plan
  __ From PCP within plan
X Grievances and appeals data
__ PCP termination rates and reasons
X Other (please describe):

MCOs are contractually required to submit regular reports. The MCO data is utilized to monitor member disenrollment, grievances, coverage/authorization and quality of care. The data is analyzed to identify trends, ensure quality health care services are provided to enrollees and to ensure MCOs are in compliance with federal, state and contract requirements. A detailed description by report type is provided below.

MCO Disenrollment Requests: **If after filing an MCO grievance an enrollee remains dissatisfied with the outcome, he or she may request MCO disenrollment through the Enrollment Broker. DHS monitors the volume of disenrollment requests received on an ongoing basis and any issues or concerns identified, such as a high volume of disenrollment requests, are acted upon promptly and would result in contractually agreed upon remedies such as corrective action.**

Grievance and Appeals Data: **MCOs are required to submit monthly data to permit DHS to monitor the volume and timely resolution of MCO grievances and appeals. State staff review the data and any non-compliance with timely processing requirements or concerns about volume of received and/or overturned grievances and appeals are acted upon promptly. MCOs are subject to liquidated damages for failure to resolve grievances and appeals in the required timeframe and non-compliance would trigger contractually agreed**

upon remedies such as corrective action plans, liquidated damages and more frequent reporting requirements.

Claims Reports: **MCOs must submit claims processing and adjudication data monthly, as well as identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. Reports include: (1) adjudicated claims summaries, claims aging summaries, and claims lag reports; and (2) claims denial reasons. These reports assist the State in monitoring MCOs' claims processing activities to ensure appropriate member access to services and payments to providers. DHS promptly reviews the data to identify non-compliance with processing timelines and outliers on claims denial rates. MCOs are subject to liquidated damages for failure to process clean claims in the required timeframe and non-compliance would trigger other contractually agreed upon remedies.**

e. **X** Enrollee Hotlines operated by State

IME Member Services staffs and operates a statewide telephone call center to assist Medicaid members in accessing services, identifying potential providers, explaining how services are provided, and helping address any issues the member may have with their Medicaid benefit. The call center staff assists members in enrolling in managed care, when applicable. DHS monitors calls received to identify trends such as topics which require additional member outreach strategies and communication materials.

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

g. **X** Geographic mapping of provider network

MCOs must submit monthly geo-access maps to allow the State to monitor member choice, PMP/specialist capacity and provider selection. This data is analyzed on a monthly basis by the IME to assess MCOs capacity to service members and access to care within reasonable travel times based on the members' residential zip code to the providers' office/facility location zip code. The State promptly reviews the geo-access reports to identify any access issues. In the event of identified deficiencies, a corrective action plan or other contractually agreed upon remedy is required.

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

The State will arrange for an independent assessment of the Iowa High Quality Healthcare Initiative and submit the findings when renewing the waiver program.

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

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

The MCO is required to document adequate network capacity at the time it enters into the contract with the State, at any time there is a significant change in the MCO's operation or the program, changes in services, changes in benefits, changes in payments, enrollment of a new population, or as otherwise requested by the State. DHS requires MCOs to develop and maintain a comprehensive network prior to the effective date of the contract and prior to receiving enrollment and shall be required during the readiness review process to demonstrate network adequacy through the submission of geo access reports. MCOs are required to have an open network until the MCO demonstrates that it meets the access requirements. If an MCO does not meet network access standards, a corrective action plan or other contractually agreed upon remedy is required, and may include maintenance of an open network for the provider type for which the MCO is non-compliant. DHS reviews provider directories yearly and when necessary to determine minimum network standards. Additionally, geo access maps are reviewed monthly as described in the Geographic Mapping of Provider Network section above.

k. **X** Ombudsman

The Iowa Office of the State Long-Term Care Ombudsman will provide assistance and advocacy services to eligible recipients, or the families or legal representatives of such eligible recipients, of long-term services and supports provided through the Medicaid program. Such assistance and advocacy shall include but is not limited to all of the following: (a) assisting recipients in understanding the services, coverage, and access provisions and their rights under Medicaid managed care; (b) developing procedures for the tracking and reporting of the outcomes of individual requests for assistance, the obtaining of necessary services and supports, and other aspects of the services provided to eligible recipients; and (c) providing advice and assistance relating to the preparation and filing of complaints, grievances, and appeals of complaints or grievances, including through processes available under managed care plans and the state appeals process, relating to long-term services and supports under the Medicaid program. A representative of the Office providing assistance and advocacy services, shall be provided access to the individual, and shall be provided access to the individual's medical and social records as authorized by the individual or the individual's legal representative, as necessary to carry out the duties specified in this section.

l. **X** On-site review

MCOs are required to undergo and must pass a readiness review process and be ready to assume responsibility for program services prior to receiving member enrollment. Post-implementation, State staff conduct quarterly visits to each contracted MCO. Site visits are utilized to review MCO compliance with federal, state and contract requirements through strategies such as onsite demonstration of operational procedures, meetings and interviews with MCO personnel, monitoring helpline calls, etc. Any problems, issues or discrepancies found during onsite reviews are acted upon promptly. Typical interventions include corrective action plans and other contractually agreed upon remedies.

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

Performance improvement projects are utilized to monitor and improve the quality of care delivered to enrollees. The MCOs develop a work plan for the Quality Management and Improvement Program, which includes performance improvement projects, to identify the goals the MCO has set to address its strategy for improving the delivery of health care benefits and services to its members. The work plan identifies the steps to be taken and includes a timeline with target dates. The plan is submitted prospectively for each year, with quarterly updates and a final evaluation of the prior year.

n. **X** Performance measures [Required for MCO/PIHP]
- **X** Process
- **X** Health status/outcomes
- **X** Access/availability of care
- **X** Use of services/utilization
- **X** Health plan stability/financial/cost of care
- **X** Health plan/provider characteristics
- **X** Beneficiary characteristics

DHS and MCOs are responsible for the performance measurement process. DHS has established performance measures that are monitored on a regular basis. The scope of the performance monitoring measures includes quality of care, access to care, customer service, member assessment, care plan development, care coordination reporting, grievance and appeals processing, provider credentialing, encounter data, claims payment, utilization management processing, quality of life reports and health outcomes and clinical reporting, including reports documenting the MCO's quality and management outcomes for individuals residing in an institutional setting or receiving home and community-based services. Additionally, MCOs produce contractually required HEDIS measures following HEDIS specifications on an annual basis. Data is used to monitor quality of care. DHS utilizes the data obtained in setting quality

strategy goals, performance standards, improvement plans and incentive payments.

o. __ Periodic comparison of number and types of Medicaid providers before and after waiver

p. __ Profile utilization by provider caseload (looking for outliers)

q. __ Provider Self-report data
   __ Survey of providers
   __ Focus groups

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

MCOs are required to ensure primary care providers (PCP) are available to member's 24 hours/7 days a week. The MCOs must conduct a 24 hour availability audit to monitor compliance with this requirement and measure timely access. The results of this audit must be submitted annually to DHS. State staff promptly review and evaluate the results of the audit. In the event 100% of providers are not in compliance, the State monitors to ensure the required follow-up is conducted, including the MCOs implementing corrective actions for network providers identified as failing to meet the standard.

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

MCOs will be required to submit service utilization reports to be monitored through desk review and onsite audits. The State will monitor the MCO compliance with utilization review criteria, assess consistency of criteria application, and if services are denied, whether members are provided timely notice of grievance and appeal rights.

t. **X** Other: (please describe):

MCOs must submit all marketing and member communication materials to the State for review and approval prior to distribution. The State reviews for accuracy and compliance with state and federal requirements such as the information requirements enumerated at 42 CFR 438.10.

Additionally, the State requires MCOs to submit a Program Integrity Plan, which documents the routine methods, on-going referrals and MCO initiatives that support program integrity compliance. This is submitted prospectively for each year, along with monthly activity reports, which outline the MCO's program integrity related activities and findings and the MCO's progress in meeting goals and objectives and recoupment totals for the reporting period.

Financial reports assist the State in monitoring MCOs' financial trends to assess stability and ability to offer services to its members. Reports include, but are not limited to, the following: (1) third party liability collections reports; (2) copies of all required filings with the Iowa Insurance Division; (3) annual independent audit; (4) disclosure of physician incentive plans sufficient to determine compliance with 42 CFR 422.208 and 42 CFR 422.210; (5) certificates of insurance; (6) all contracts of reinsurance or a summary of the plan of self-insurance; (7) any/all health care claims costs paid by the MCO's commercial reinsurer due to meeting the reinsurance attachment point; and (8) a medical loss ratio report.

Section C: Monitoring Results

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

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

X This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.
__ This is a renewal request.
__ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
__ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should: (1) confirm it was conducted as described in Section B of the previous waiver preprint (if it was not done as described, please explain why); (2) summarize the results or findings of each activity (CMS may request detailed results as appropriate); (3) identify problems found, if any; (4) describe plan/provider-level corrective action, if any, that was taken (the State need not identify the provider/plan by name, but must provide the rest of the required information); and (5) describe system-level program changes, if any, made as a result of monitoring findings.

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

Strategy:
Confirmation it was conducted as described:
__ Yes
__ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level):

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: **Mikki Stier**
c. Telephone Number: **515-256-4621**
d. E-mail: **mstier@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.*

Not applicable. This is an initial waiver.

a.___ 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):

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:

a._**X**_ Population in the base year data

1._**X**__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._**X**__[Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: **Member month projections are based on historical state experience as well as anticipated changes between the base year and prospective years in the Medicaid, Iowa Health and Wellness, and Family Planning Waiver populations**.

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

e._ **X** _[Required] List the year(s) being used by the State as a base year: **State fiscal year 2014**. If multiple years are being used, please explain:_____

f._**X**_ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period **State fiscal year (SFY)**

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: **Not applicable.**

a.___ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ 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.___ [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/R1 to P2: ____

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

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

For Initial Waivers:

a.__**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.

Dental, School-Based, Money Follows the Person, and Iowa Veteran's Home services are not included in the IHQHI waiver. State supplemental payments to members residing at Residential Care Facilities are also excluded.

For Conversion or Renewal Waivers: **Not applicable.**

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

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

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

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

For Initial Waivers:

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

Although this is an initial waiver, some of the services have been capitated in the past. The state's administrative costs are not expected to increase by items other than trend under the IHQHI waiver. Thus, no additional administration expenses are being reflected in the Appendix D materials.

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.***

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**.

Although this is an initial waiver, the state has been providing 1915(b) services through its Iowa Plan for Behavioral Health 1915(b) waiver. The amount included in the retrospective period is the portion of the capitation payments made under the Iowa Plan for b(3) services. The PIHP's encounter data was used to split the capitations into State Plan and B(3). The information in the table below includes trend as well as the impact of any other adjustments between the retrospective period and the prospective period.

1915(b)(3) Service	**Amount Spent in Retrospective Period**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
1915(b) capitations paid by service were not tracked separately in the base year.	***$15,579,790 or $2.72 PMPM BY***	***6.3% in P1***	***$2.89 PMPM in P1***

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections
Please see the table above.

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*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

	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
Not applicable.

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*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

Basis and Method:

1._**X**__The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs ~~to 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:

1.__**X**__[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.

There were no incentive payments made during the BY experience and are reflected as $0 in Appendix D.3. Under IHQHI, the MCOs will be eligible for an incentive payment of 2% of capitations, upon meeting certain performance and clinical outcomes.

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.

Historical amounts paid to PCCM providers is included under the MCO/PIHP capitated costs column on Appendix D.3 as instructed. The amounts were $4,330,246 for TANF and $740,584 for Expansion.

Current Initial Waiver Adjustments in the preprint

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

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

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

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

1. **X** [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: **3% annually from BY to P1, and 4% thereafter**. Please document how that trend was calculated:

Trend is a combination of historical experience which includes legislated trend supplemented with internal trend sources and judgement. An annual state plan, 1915(b)(3), and 1915(c) trend of 3% was used. Additionally, the trend adjustment includes a one-time 2% reduction to the base costs. This 2% reduction was to shift costs to the incentive costs category, where the withhold payments may be monitored. Finally, program and policy change adjustments were included in the 1915(b)(3) and 1915(c) trend factors to avoid altering the structure of the Appendix D workbook.

An annual 4% trend was used for P1 to P5.

2. _**X**_ [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. _**X**__ State historical cost increases. Please indicate the years on which the rates are based: base years_**SFY 13-SFY14**_____ 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._**X**__ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_**proprietary data sources**_____. 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.

   Cost is primarily driven by legislation. Overall trend was estimated by categories of service using historical data, proprietary data sources, and actuarial judgement.

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. _**X**_ **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._**X**__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. **X** Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

E.____

- **Pharmacy Dispensing Fee - The State of Iowa increased the pharmacy dispensing fee to $11.73 on August 2014 (previously $10.12). This reflected an estimated impact to the pharmacy expenditures of $10.4 million or approximately 3.5%.**

- **Ambulance - The State of Iowa increased the reimbursement to ambulance providers by 10% on July 1, 2014.**

- **Nursing Home providers - The State of Iowa increased the reimbursement to nursing home providers by $2.8 million or approximately 0.4% on July 1, 2014**

The following describes the policy and program changes that occurred on July 1, 2015.

- **Nursing Facility Rebase: Intermediate Care Facility provider category of service (COS 25) less the Iowa Veterans Home plus client participation amounts not included in the MMIS reimbursement amount. The fiscal impact was $29.8 million.**

- **Increased Nursing Facility Spend due to Assessment Increase: Intermediate Care Facility provider category of service (COS 25) less the Iowa Veterans Home, Nursing Facility for the Mentally Ill provider category of service (COS 27), and Skilled Nursing Facility provider category of service (COS 20). The fiscal impact was $8.1 million.**

- **Waiver Management: Two components: (1) thorough review of exception to policy and (2) standardized assessments. The fiscal impact was ($8.7) million or (1.27%).**

c. **X** **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._**X**__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.__**X**_ [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 **___6.3% from BY to P1 (2.2% annually) and 4% annually thereafter.**

* 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. **_X_** [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: **3.0% annually based upon historical experience**_. Please provide documentation.
2. **_X_** [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 _____.

1915(B)(3) trend has been limited to the lesser of the historical B(3) experience and the state plan trend.

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**.**_(see table below)____**
2. List the Incentive trend rate by MEG if different from **Section D.I.I.a _2% of capitations; applies to all MEGs**_____
3. Explain any differences:

Under IHQHI, the MCOs will be eligible for an incentive payment of 2% of capitations, upon meeting certain performance and clinical outcomes.

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._**X**__We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___ Other (please describe):

The base data has been adjusted to include a GME payment of $23,000,000. GME was historically made as a lump sum payment and not tied to a particular member. Thus all historical GME payments have been allocated to the TANF MEG.

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._X__GME adjustment was made.
   i.__X_ 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.__X_Other (please describe):

Under the IHQHI, GME payments are included in the capitation rates forthe TANF and Disabled non-Dual populations along with certain nursing facility and 1915(c) waiver populations which qualify for GME payments. This impacts the TANF, Aged/Blind/Disabled non-Dual, LTSS Non-Dual and/or Pre-65, LTSS – Intellectual Disability, and LTSS-Children's Mental Health MEGs. The allocation of GME payments was on a PMPM basis for P1 of $5.28 for an annual collection of $21.4 million.

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. **X** Payments outside of the MMIS were made. Those payments include (please describe): **Plan mass adjustments made for behavioral health services. These payments amounted to approximately $8 million in SFY 2014. These payments were included in Appendix D3.**

2. **X** Recoupments outside of the MMIS were made. Those recoupments include (please describe): **(1) TPL; (2) program integrity; (3) claim error; (4) HCBS reviews; and (5) other recoupments. Total recoupments in SFY 2014 amounted to approximately $24 million. Recoupments were removed from the expenditures illustrated in Appendix D3.**

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._**X**_ The State has not made an adjustment because the same copayments are collected in managed care and FFS.

4.__ Other (please describe):

The MCOs shall impose copayments following the state's current policies. Paid data (already adjusted for copays) was used in the analysis.

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._**X**_ 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):

The MCOs will collect and keep TPL. The base data was based on paid amount, after TPL was removed.

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._**X**_ 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):

Pharmacy was reduced by 48% for rebates collected in SFY 2014. This is reflected in the base data shown in Appendix D.3.

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._**X**_ 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.

2.___ **X** This adjustment is not necessary as there are no voluntary populations in the waiver program.
3.___ 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:

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

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):

The MCOs are required to reimburse FQHCs and RHCs at the prospective payment system (PPS) rate in effect on the date of service for each encounter. This is similar to the base year for most providers. An adjustment was made from the base experience to account for the reduction in payment for providers that received interim cost-based rates down to the PPS rate.

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._**X**__ 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).

Not applicable.

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.___ **X** Other (please describe):

In this Initial Waiver, the BY FFS experience includes claims incurred during SFY 2014, completed for claims not yet paid. P1 represents the capitation payments expected to be paid during CY 2016, beginning April 1. Going forward, the waiver will be reported and monitored on a paid basis.

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:

The waiver will not include PCCM.

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.___ **X** 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.

Not applicable.

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.___ [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: _____. Please document how that trend was calculated:

2.___ [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. ____ 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 _____. 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. ____ **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.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

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

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

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

2.___ An administrative adjustment was made.

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

ii.___ Cost increases were accounted for.

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

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

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

D.____Other (please describe):

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.___ [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: _____. Please provide documentation.

2.___ [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_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

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

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

- ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

  Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

Member month projections are based on historical state experience as well as anticipated changes in the Medicaid, Iowa Health and Wellness, and Family Planning Waiver populations.

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**:

Trend is a combination of historical experience which includes legislated trend supplemented with internal trend sources and judgement.

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**:

Trend is a combination of historical experience supplemented with internal trend sources and judgement.

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

Adjustments to the BY also included the impact of program changes, addition of GME payments, reduction of costs for pharmacy rebates, and payments/recoupments made outside of the MMIS.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.