
7A.5 Budget Worksheet and Description

Bidders are not asked to submit a cost proposal. Bidders must understand that the rates have already been set and Bidders must accept them as is for the first contract year. Payment rates are provided as Attachments to Section 9. The Bidder is required to complete the attached budget worksheet to assist the Department’s understanding of how the Bidder proposes to influence changes in care delivery and financing within the Iowa Plan. In addition, the Bidder shall provide a narrative describing:

- **the Medicaid capitation payment allocations between the Medicaid Claims Fund and the Medicaid Administrative Fund in the Proposal Pricing Tables. Bidders should note that the percent of the Medicaid capitation payment allocated to the Medicaid Administrative Fund, including profit, cannot exceed 13.5%;**
- **the percentage of the IDPH payment that the Bidder proposes to allocate to the IDPH Administrative Fund. Bidders should note that the percent of the IDPH payment allocated to the IDPH Administrative Fund, including profit, cannot exceed 3.5% of available IDPH Iowa Plan funding, and**
- **how the Bidder proposes using the Community Reinvestment Account (Section 9 describes the requirements pertaining to the Community Reinvestment Account).**

A description of the payments to the Contractor can be found in Section 9.

Acceptance of Rates: We have reviewed and accept the contract rates for the first contract year as outlined in the Attachments to Section 9.

Budget Worksheet: Please see *Attachment – Budget Worksheet* in the Attachments Appendix. It is reflective of the changes in utilization we anticipate through the implementation of our CSP model. Also, it reflects an overall decreased per member per month cost as we expect that our CSP model will allow us to manage the contract within the decreased revenue as anticipated by the Departments.

Influencing Changes in Care Delivery and Financing Within the Iowa Plan: During the first contract year, we will use a fee-for-service reimbursement system and will not require prior authorization for non-facility based services. During contract negotiations and throughout the first year, we will work with Comprehensive Service Providers (agencies contracted to provide access to a full continuum of coordinated recovery-oriented services) to develop improved coordination processes with the goal of reducing unnecessary reliance on inpatient and other higher levels of care. We will continue to identify service and/or capacity gaps and work to develop needed services including mobile crisis services; community-based / community support services, including in-home services; 24 hour crisis evaluation services, service coordination; ACT teams and peer support services.

In the second year, we will transition the Comprehensive Service Providers (CSP) to a block payment methodology while retaining a fee-for-service system for non-CSP providers, including specialty providers and acute levels of care. We will reimburse acute levels of care on a fee-for-service basis in order to properly account for and manage care for consumers admitted to inpatient and residential settings.

Block payment reimbursement is a strategy that empowers larger multi-service providers in the overall care of those they serve. CSP receive lump sum payments by fund type (Medicaid, State-only funding, and grant funds) each month and manage the dollars to cover services. CSP are accountable for their spending and are required to submit encounters for services to be equal to or greater than their contract amounts. The primary advantages to this payment strategy are that it improves care and outcomes by allowing the provider to coordinate waivers and wrap around services in addition to traditional outpatient services. The coordination of care is centralized with the CSP. It brings more of the right services to bear for each individual. Administratively, block funding eliminates claim-to-pay lag time.

The elimination of prior authorization requirements for most levels of care does result in additional initiative on the part of the managed care organization to find new strategies for quality accountability. Achieving quality accountability using a block payment methodology requires intensive monitoring of service funding prioritization relevant to providing adequate access across populations and continuum of services. Such monitoring also allows Cenpatico to allocate funds across the network to ensure that service priorities set by

the State are met, and that variances in regional needs are addressed. These priorities and requirements include:

- Prioritization of Population Types
- Specific Projects with providers to match the prioritization, including mobile teams, crisis telephone, community re-entry, rapid response assessments, parents at risk of child removal.
- We require providers ensure availability of services throughout the year for the project.
- We track encounters to ensure delivery of services, and prevent over-delivery.
- We require providers use a sliding fee scale approved by the State.
- We require specific reports related to specific populations – HIV screening, pregnant and parenting women, IV drug users, etc.

The **financial impact of our model** is that providers deliver the most appropriate services to our consumers for *their* stage in recovery leading to faster integration within the community and resulting in less costly care over their lifetime. Expanding the support systems around individuals reduces admissions and greatly decreases the likelihood of readmission. By building needed services and contracting in this way, we anticipate a cost shift of direct service costs from inpatient and residential services to outpatient and community treatment.

Cenpatico has a proven track record of learning our customers' markets and partnering with providers in order to effectively reduce costly inpatient and residential services by identifying, building, and offering more supportive services that help prevent admissions to higher levels of care. For example, our efforts to increase access to supportive services in our Arizona market showed an inverse relationship between increased supportive service utilization and decreased inpatient utilization over the same period of time. Similar methodologies will be carried out for the Iowa Plan.

Our budget worksheets reflect this commitment and expected outcomes. We anticipate decreasing higher level of care costs between 1% and 3% for both substance abuse and mental health, while increasing utilization of services that maintain Eligible Persons in their homes and communities. By developing Comprehensive Service Providers and crisis support systems, we will reduce inpatient utilization while providing more community based services, peer support, and crisis intervention.

Allocation of Funds: Using the block payment methodology enables both providers and Cenpatico to better manage funding. Of the total monthly capitation, 2.5% will be placed into the Community Reinvestment Fund. We anticipate that the Medicaid Claims Fund will be 84.0% of the monthly capitation amount, and the Administrative Fund, including profit, will be equal to 13.5%. Of the IDPH funding, we propose 3.5% will be allocated to the IDPH Administrative Fund. Any portion of either claims fund that is not expended will go into the community reinvestment fund, and any interest earned on the claims fund account will be returned to the state at the end of each quarter.

Community Reinvestment: Our CSP network model is ideal for allocation, distribution and accounting for provision of the community reinvestment funds. Of the monthly capitation amounts, 2.5% will be placed in the Community Reinvestment Fund.

70% of the Community Reinvestment Fund is allocated for member services and 30% of the Community Reinvestment Fund is allocated for provider development and consumer/family education and outreach. We target the following areas for investment:

- Expansion of crisis intervention and mobile crisis services
- Expansion of Assertive Community Treatment services
- Creating and expanding services for community re-entry from incarceration
- Support and develop consumer employment services

- Creating a certification program for peer support specialists to increase availability of peer support services
- Addressing behavioral health care workforce shortage, including developing specific Behavioral Health Certification program in conjunction with local community colleges
- Creating outreach and education programs to increase awareness of behavioral health issues in order to reduce the stigma associated with behavioral health diagnoses