DHS-019 Amendment to the Iowa Plan for Behavioral Health Contract

This 19th Amendment to Contract Number MED 09-020 is effective as of July 1, 2012, between the Iowa Department of Human Services, the Iowa Department of Public Health, and Magellan Behavioral Care of Iowa, Inc. (Contractor).

Section 1. Amendment to Contract in the Iowa Plan Request for Proposal Attachments (No 09-010): Section 9. The Contract is amended and supplemented as follows:

The parties mutually agree to adopt the Iowa Plan Performance Indicators as attached for the period of July 1, 2012 to June 30, 2013.

Section 2: Ratification & Authorization. Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and this Amendment constitutes a legal, valid and binding obligation upon itself in accordance with its terms.

Section 3: Execution. *IN WITNESS WHEREOF,* in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Iowa Department of Human Services	
Signature: C M Palmer	
Printed Name: Charles M. Palmer	
Title: Director	Date: 9-19-12

Iowa Department of Public Health	
Signature: Kathy Stone	
Printed Name: Kathy Stone	
Title: Director Division of Behavioral Health	Date: 8/24/12

Contractor, Magellan Behavioral Care of Iowa, Inc.	
Signature: Anne M McCabe	
Printed Name: Ann McCabe	
Title: President	Date: August 21, 2012

Iowa Plan for Behavioral Health
Performance Indicators
July 1, 2012 – June 30, 2013

PERFORMANCE INDICATORS
CARRYING MEDICAID FINANCIAL INCENTIVES
IOWA PLAN FOR BEHAVIORAL HEALTH

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial incentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.
The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

The Contractor shall be paid the amount the Department of Human Services has associated with each indicator. The Department of Human Services shall be solely responsible for determining whether or not the Contractor has met the required level of performance. The Department shall take whatever steps it deems appropriate to validate all information provided by the Contractor, including auditing Contactor measurement processes and data, prior to issuing incentive payments.

1. Quality of Care: Mental Health Readmission
   Rate of mental health inpatient readmission by children and adults at 7, 30, and 90 days will be no higher than the following:

7-day readmission (monitor only)	30-day readmission	90-day readmission(monitor only)
children: 6.0%	children: 14.0%	children: 25.0%
adults: 6.0%	adults: 14.0%	adults: 25.0%

Numerator: The number of inpatient readmissions within 7/30/90 days of discharge.*
Denominator: The number of inpatient discharges that occur within the reporting periods, less 7, 30, or 90 days.*

*Discharges/readmits at the MHIs where the Enrollee is moving between inpatient and residential are not counted. Court ordered inpatient admissions are not counted.
Data Source: Claims.

Standard	7-day readmission (Monitor Only)	30-day readmission (Incentive)	90-day readmission (Monitor Only)
	6% or less	14% or less	25% or less

2. Quality of Care: Community Tenure

The average time between mental health hospitalizations per contract period shall not fall below 94 days for Iowa Plan Enrollees.

For Enrollees who were admitted to a mental health inpatient hospital setting which is funded by the Contractor and subsequently readmitted to a mental health inpatient hospital setting funded by the Contractor within the contract period and the preceding 12 months of the contract period, the average number of days between discharge and readmission(s). The numbers must reflect all Enrollees who were re-admitted despite Contractor denial as well as those Enrollees whose admission was authorized.

Data Source: Authorizations.

Standard	94 days or more (children) before readmission – (monitor only) 94 days or more (adults) before readmission – (monitor only) 94 days or more (children and adults) before readmission – (incentive)

3. Service Array: Integrated Services and Supports -

At least 18% of mental health service expenditures, combined for children and adults, will be used in the provision of integrated services and supports, including natural supports, consumer-run programs, and services delivered in the home of the Enrollee.

Numerator: The Contractor's combined mental health expenditures for integrated services and supports, consumer-run programs, and services delivered in the Enrollee's home, but also reported separately for adults and children

Denominator: The Contractor's total claims expenditures for mental health services, but also reported separately for adults and children.

Data Source: Claims.

Standard	% of child MH service expenditures – (monitor only) % of adult MH service expenditures – (monitor only) 18% or more of MH service expenditures – (incentive)

4. Quality of Care: Follow-up Contact After Hospitalization for Mental Illness

90% of Enrollees discharged from mental health inpatient care will receive a follow-up contact by a provider or by Magellan staff within 7 days of discharge.

Numerator: The number of Enrollees discharged from a mental health inpatient setting (whether or not the inpatient hospitalization was authorized by the contractor at the time of discharge) during the contract period for whom claims data or other information from a provider reflects subsequent treatment service or a follow-up with Magellan's Staff within 7 calendar days of the discharge date.

Denominator: The number of Enrollees discharged from a mental health inpatient setting (whether or not the inpatient hospitalization was authorized by the contractor at the time of discharge) during the contract period.

Excluded: Clients not enrolled in the Iowa Plan at the time of discharge are excluded, even those clients who later gain Iowa Plan enrollment for the month of service. Clients determined to be admitted for a non-Iowa Plan diagnosis.

Data Source: Authorizations, IP Medical Record and claims.

Standard	90% of Enrollees receive follow-up treatment within 7 days of discharge

5. Quality of Care: Follow-up After Hospitalization for Mental Illness (modified HEDIS)

58% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 7 days of discharge.

76% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 30 days of discharge.

National benchmarks:

Description	P25	P50	P75	P90
FUH-07D	33	44.5	58	68
FUH-30D	49.6	64.3	75.7	81.2

Numerator and Denominator: utilize HEDIS 2011 specifications for the measure "Follow-Up After Hospitalization for Mental Illness"

Exclude: enrollees with Medicaid and Medicare

Data source: claims and enrollment

Standard	58% or more within 7 days of discharge (incentive) 76% or more within 30 days of discharge (monitor only)

6. Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment

60% of Enrollees discharged from ASAM Levels III.5 and III.3 will receive a follow-up substance abuse service within 14 days of discharge

Numerator: The number of Enrollees discharged from ASAM Levels III.5 and III.3 who received a follow-up substance abuse service reimbursed by the Contractor within 14 days (as documented in the Contractor's claim system) of discharge.

Denominator: The number of Enrollees discharged from ASAM Levels III.5 and III.3.

Exclude: Enrollees with Medicaid and Medicare

Data Source: Authorizations and claims.

Standard	60% of Enrollees receive follow-up treatment within 14 days of discharge

7. Quality of Care: Implementation of Mental Health Inpatient Discharge Plans

94% of all discharge plans written for Enrollees being released from a mental health inpatient hospitalization shall be implemented. (Minimum of 240 charts).

Numerator: Number of Enrollees* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge) for whom claims data or provider records reflect implementation of the follow-up plan written with the Enrollee at the time of discharge.

Denominator: Number of Enrollees* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge).

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data Source: Chart Review.

Standard	94% or more of all discharge plans are implemented Minimum of 240 charts

8. Quality of Care: Outcome Measurement – Medicaid Children and Adolescents

The Contractor shall support Medicaid child and adolescent Enrollees such that at least 50% of children and adolescents receiving Iowa Plan outpatient services report improvement in the psychosocial domain as reported by comparison of initial and most recent assessment using the Consumer Health Inventory for Children (CHI-C).

Numerator: : The total number of Enrollees, age 0 - 17, that have at least 2 CHI scores with the most recent during the reporting period, where improvement is shown from the first to the most recent score.

Denominator: The total number of Enrollees, age 0 - 17, that have at least 2 CHI scores with the most recent during the reporting period.

Data Source: CHI-C Outcomes Assessment Report

Standard	At least 50% report improvement Report aggregate improvement from initial to follow up administration

9. Service Coordination and Integrated Treatment

Members receiving both Iowa Plan clinical services and BHIS services will increase by 5% of the 2012 baseline during the year.

Numerator: The total number of distinct enrollees who are in the denominator who also receive an Iowa Plan clinical service with a date of service at any time during the 12-month measurement period.

Denominator: The total number of distinct enrollees receiving BHIS services with a date of service at any time during the 12-month measurement period.

Data source: claims (calculations are cumulative for dates of service during the 12 month measurement period for any paid date up to the time the report is produced)

Standard	5% increase by year end
Baseline (SFY 2012)	63.5% Based on SFY 2012
Performance YTD (SFY 2013)	%
Contract Period to Date	XX% increase

10. Quality of Care: Implementation of Group Care Discharge Plans

90.7% of all discharge plans written for Enrollees being released from a group care setting shall be implemented (minimum of 60 charts).

Numerator: The number of enrollees who have been discharged from a group care placement during the contract period for whom claims data or provider records reflect implementation of the follow-up plan written with the enrollee at the time of discharge. *

Denominator: The number of enrollees who have been discharged from a group care placement during the contract period. *

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data source: chart review

	Contract Period to Date
% with discharge plan implemented	xx.x%
Number of charts with d/c plan implemented	xx
Number of charts reviewed	xx
Providers visited	xx
Standard	90.7% or more of all discharge plans are implemented (incentive) Minimum of 60 charts (annual number)

MEDICAID PERFORMANCE INDICATORS WITH FINANCIAL DISINCENTIVES IOWA PLAN FOR BEHAVIORAL HEALTH

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial disincentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurement (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

Disincentives shall be assessed solely at the discretion of the Department of Human Services. The Departments shall take whatever steps they deem appropriate to validate all information provided by the Contractor, including auditing Contactor measurement processes and data.

1. Consumer Involvement

New Enrollee information, including a list of network providers, will be mailed to each new Enrollee in the Iowa Plan within 10 working days after the first time his or her name is provided to the Contractor.

When the name of a new Iowa Plan Enrollee is provided to the Contractor, the Contractor shall mail required new Enrollee information on Iowa Plan services within 15 working days. The standard shall be met for 95% of Enrollees, and in no case shall more than 15 working days elapse before all new Enrollees are mailed enrollment information.

Data Source: Manual Tracking System.

Standard	95% within 10 working days 100% within 15 working days

2. Quality of Care: Mental Health Discharge Plan

A discharge plan shall be documented on the day of discharge for 90% of Enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan shall include, at a minimum: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) if applicable, restrictions on activities and when the Enrollee can return to work or school, including the school setting.

Numerator: The number of Enrollees* who have been discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment for whom a discharge plan was documented in the record on the day of discharge.

Denominator: The number of Enrollees* discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment settings.

Note: This measure excludes Enrollees who left treatment against medical advice.

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

Data Source: Retrospective Chart Reviews.

Standard	90% or more with documented discharge plan at discharge

3. Quality of Care: Discharge to Homeless or Emergency Shelter

The percentage of Enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 1.0% of all mental health inpatient discharges of children under the age of 18.

Numerator: The number of Enrollees under the age of 18 who were transferred to a homeless or emergency shelter upon discharge from mental health inpatient care.

Denominator: The number of Enrollees under the age of 18 who were discharged from mental health inpatient care.

Note: Enrollees may be excluded if discharged upon the signed recommendation of a DHS or JCS worker.

Data Source: Authorizations.

Standard	≤ 1.0% of all MH discharges of children < 18

4. Quality of Care: Follow-up on Emergency Room visits

95% of Enrollees who received services in an emergency room shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.

Numerator: The number of Enrollees who were served in an emergency room, who received a documented follow-up contact within 3 business days of the date the Contractor was notified of the emergency room service.

Denominator: The number of Enrollees who were served in an emergency room and the Contractor was notified of the emergency room service.

Note: Documented follow-up may include treatment at a 24-hour setting to which the Member returned or was admitted following the ER presentation. In addition, documented follow-up includes Contractor's attempt to reach the Enrollee telephonically for each 24-hour period up to 3 business days and a subsequent letter to the Member within 3 business days if the Enrollee could not be reached telephonically.

Data Source: ER Tracking System.

Standard	Follow-up contact with 95% or more within 3 business days

5. Quality of Care: Participation in Joint Treatment Planning Conferences

The Contractor shall arrange or participate in at least 20 Joint Treatment Planning conferences per month, and 450 per year.

The number of times during the contract period in which staff representing the Contractor participated in prescheduled conference calls or face-to-face meetings in which persons authorized to commit funds from at least one other funding stream worked w/or on behalf of an Enrollee to design or revise a treatment plan.

Data Source: JTP Tracking System.

Standard	Arrangement or Participation in at least 20 JTPC per month, and 450 or more per year

6. Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment

At least 63% of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge. Enrollees that left treatment AMA are excluded.

Numerator: The number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) who received a follow-up substance abuse service reimbursed by the Contractor within 30 days of discharge (as documented in the Contractor's claim system). Enrollees that left treatment AMA are excluded.

Denominator: The number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House). Enrollees that left treatment AMA are excluded.

Exclude: Enrollees who leave against medical advice (AMA)
Data Source: Authorizations and Claims.

Standard	63% receive follow-up SA service within 30 days of discharge

7. Quality of Care: Substance Abuse Treatment Discharge Plan

A discharge plan shall be documented on the day of discharge for 90% of Enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting.

Numerator: The number of Enrollees* who have been discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting for whom a discharge plan was documented in the record on the day of discharge.

Denominator: The number of Enrollees* discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting.

Note: This measurement excludes Enrollees who left treatment against medical advice. This measure may be done based on a random sample of record audits.

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

Data Source: Retrospective Chart Reviews.

Standard	90% or more with discharge plan at discharge

8. Claims Payment

Medicaid claims shall be paid or denied within the following time periods:

- 90% within 12 calendar days
- 99% within 30 calendar days
- 100% within 90 calendar days

Times shall be calculated from the date the claim is received by the Contractor until the date the check or denial letter is mailed to the provider.

Data Source: Claims.

Standard	90% within 12 calendar days 99% within 30 calendar days 100% within 90 calendar days

9. Appeal Reviews

95% of appeals will be resolved as expeditiously as the Enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.

In the event of an extension, 95% of the time the Contractor shall resolve the appeal within the additional 14-calendar-day period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.

Data Source: Appeal Tracking System.

Standard	95% appeals resolved within 14 calendar days 100% appeals resolved within 45 calendar days 95% of extended reviews resolved within 14 calendar days from the end of the initial 14-day period

10. Expedited Appeal Reviews

100% of expedited appeals will be resolved as expeditiously as the Enrollee's health condition requires and within 72 hours from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension.
In the event of an extension, 95% of the time the Contractor shall resolve the appeal within 14 calendar days from the end of the 24-hour period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.

Data Source: Appeal Tracking System.

Standard	100% appeals resolved within 72 hours of receipt 95% of extended reviews resolved within 14 calendar days from the end of the 24-hour period

11. Grievance Reviews

95% of grievances will be resolved as expeditiously as the Enrollee's health condition requires and within 14 days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 60 calendar days of the receipt of all required documentation.

Data Source: Grievance Tracking System.

Standard	95% grievances resolved within 14 days, 100% resolved within 60 days

12. Network Management

Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.

Completion time shall be tracked from the time all required paperwork is provided to the Contractor until the time a written communication is mailed or faxed to the provider notifying them of the Contractor's determination.

Data Source: Credentialing Tracking System.

Standard	60% credentialed within 30 days, 100% within 90 days

13. Network Management

Revisions to the Provider Manual shall be distributed to all network providers at least 30 calendar days prior to the effective date of the revisions.

Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.

Note: With approval from the Departments, the time period preceding the effective date of a change may be less than 30 days if the change confers a benefit on providers or those served through the Iowa Plan.

Data Source: Manual.

Standard	Distributed 30 days or more prior to effective date

14. Quality of Care: Discharge from Group Care Facilitiy

Magellan staff will notify the DHS or JCO of the member prior to nonauthorizing any BHIS group care service 95% of the time.

Numerator: The number of nonauthorizations for BHIS group care which indicate that either the DHS or JCO of the member was notified prior to the nonauthorization being issued.
Denominator: The total number of nonauthorizations for BHIS group care.

Data source: Authorization data

	2012		2013	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% of children				
Standard	95% or more			

15. Quality of Care: Treatment continuity

High volume BHIS providers (50 or more clients) will have a regularly scheduled review time to ensure access to Magellan's care management.

Numerator: The number of high-volume providers for whom a regularly scheduled review time is established.
Denominator: The total number of high-volume providers.

Data source: Tracking spreadsheet and authorization data

	2012		2013	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
# of Providers				
Standard	High Volume Providers with Scheduled Review Time			

IDPH PERFORMANCE INDICATORS
CARRYING LIQUIDATED DAMAGES
IOWA PLAN FOR BEHAVIORAL HEALTH

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which disincentives have been attached. These indicators will be reassessed annually by IDPH and may be modified annually at IDPH's discretion. Each indicator should be reported with either monthly or quarterly measures (as specified) and with a contract year-to-date measure.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

The Department of Public Health shall be solely responsible for determining whether or not the Contractor has met the required level of performance.

1. Minimum Number Served: The Contractor shall at least serve the minimum number of unduplicated IDPH Participants. Methodology: Number of unduplicated IDPH Participants in accordance with contract condition with IDPH source of payment. Data Source: Central Data Repository (CDR)	
Standard	Minimum unduplicated number of IDPH Participants: 19,154 (Annual Number)

2. Use of Service Necessity Criteria:

90% of all retrospectively reviewed records for IDPH Participants will document the appropriate use of ASAM PPC2-R by network providers.

Date Source: Provider Records.

Standard	90% appropriate use of service necessity criteria

3. Network Development:

Contractor will work with IDPH and a Provider workgroup to establish approved provider incentive measures for the 2012-2013 contract year by October 1, 2012. Contractor will implement incentive measures process, including but not limited to, monitoring provider performance, reporting performance to providers and IDPH, and projecting provider payments for approval by IDPH.

Date Source: CDR.

Standard	Incentive measures process implemented and reported to IDPH

4. Timely Receipt of Care :

90% of IDPH Participants who request and are in need of treatment for IV drug abuse are admitted to the IV drug treatment program not later than 14 days after making the request for admission, or 120 days after the date of the request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.

Numerator: The number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 14 days of making the request *when program capacity exists at the time of the request.*
Denominator: The number of IDPH Participants who request and are in need of IV drug abuse treatment *when program capacity exists at the time of the request.*

Numerator: The number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 120 days of making the request *when program capacity does not exist at the time of the request.*
Denominator: The number of IDPH Participants who request and are in need of IV drug abuse treatment *when program capacity does not exist at the time of the request*

Data Source: Provider Records.

Standard	90% or more in treatment within 14 days of request (capacity exists) 90% or more in treatment within 120 days of request (capacity doesn't exist)

IDPH PERFORMANCE INDICATORS
Monitor Only

1. Client Mix

The Contractor shall maintain the appropriate percentages of IDPH Participant client mix.

Methodology: Percent of IDPH Participants in accordance with contract conditions with IDPH source of payment.

Numerators: The number of IDPH Participants that meet the category description.
Denominator: The total number of IDPH Participants served.

Data source: CDR

	Standard
Women:	27.8%
Pregnant:	4.3%
Criminal justice referral source:	63.9%
Unemployed:	30.7%
Race other than white:	12.5%
Prior substance abuse treatment:	41.3%
Monthly taxable income under $1000:	65%

2. Access

The contractor shall ensure that 75% or more of IPDH participants recommended for an Iowa Plan level of care are admitted to an Iowa Plan level of care within 5 calendar days.

Numerator: The number of IDPH Participants that receive an assessment (placement screen date) and are recommended for treatment who are admitted to services (admission date).

Denominator: The number of IDPH Participants that receive an assessment (placement screen date) and are recommended for treatment.

Data source: CDR

Standard	**75% or more**

MEDICAID PERFORMANCE INDICATORS

MONITORING ONLY

The Contractor shall provide to the Departments a monthly written report on all monitoring-only performance indicators. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.
The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

Consumer Involvement and Quality of Life

1. The Contractor shall conduct an annual Iowa Plan Eligible Person experience of care survey that assesses experience of care with mental health and substance abuse services for both child and adult populations.

- The survey instruments shall be standardized, validated tools approved by the Departments and shall address areas recommended by the Recovery Advisory Committee.
- The number of surveys distributed shall represent at least the minimum number required to comprise a statistically valid sample of those Iowa Plan Eligible Persons who have accessed services in the past six months.
- The acceptable response rate shall be determined by DHS and IDPH, in consultation with the Contractor.
- Results shall be reported to Iowa Plan Eligible Persons as well as corrective actions implemented in response to findings of the surveys.

Standard	Consumer Surveys conducted twice per contract year and results reported

2. Based on the annual Eligible Person experience of care survey, 85% of respondents indicate satisfaction with services provided by the Iowa Plan.	
Standard	85% or more respondents express satisfaction

Access and Array

3. The number of Iowa Plan Enrollee reported overall and separately for children and adults, for whom integrated services, rehabilitation, or support services were provided during the month, shall be 1% or more.

Data Source: Paid Claims Data.

Standard	1% or more received integrated services, rehabilitation, or support services

4. The Contractor shall demonstrate compliance with the following access standards: Enrollees with emergency needs within 15 minutes of presentation or telephone contact with Contractor or provider; Enrollees with urgent, non-emergency needs seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with Contractor or provider; Enrollees with persistent symptoms within 48 hours of reporting symptoms; Enrollees with the need for routine services within 4 weeks of the request for an appointment. (Reported quarterly as YTD)	
Standard	Emergency: within 15 minutes of presentation or telephone contact Urgent: within 1 hour of presentation or within 24 hours of telephone contact Persistent Symptoms: within 48 hours of reporting symptoms Routine Services: within 4 weeks of request for appointment

5. The Contractor shall demonstrate compliance with geographical standards of access (Urban--inpatient 30 minutes; outpatient 30 minutes. Rural--inpatient 45 minutes; outpatient 30 minutes).	
Standard	Urban: Inpatient 30 minutes; Outpatient 30 minutes Rural: Inpatient 45 minutes; Outpatient 30 minutes

6. The Contractor shall provide services to at least 16.0% of Iowa Plan Enrollees annually, reporting the unduplicated number and the percentage of Enrollees in the Iowa Plan receiving services.

Numerator: The unduplicated number of Enrollees receiving at least once service reimbursed by the Contractor.

Denominator: Unduplicated number of Enrollees.

- Also report using the following stratifications:
  - Ages 0-12, 13-17, 18-64 and 65 and older

Data Source: Claims and Enrollment.

Standard	16.0% or more receive services annually Other Measures – Monitor Only

Appropriateness

7. The average length of stay for Enrollee mental health inpatient services for any given month shall not exceed the ALOS previously under FFS (12.0 days) and shall not fall below 5.0 days for acute services unless explicitly agreed upon by the Departments with the Contractor.	
Standard	ALOS less than 12 days, but not less than 5 days

Provider Satisfaction

8. The Contractor shall conduct an annual provider survey in which at least 80% of responding network providers indicate satisfaction, and shall report key findings to the Departments, including identified opportunities for improvement.	
Standard	80% or more providers satisfied

9. Quality of Care: Involuntary Hospitalization The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 10% of all child admissions and 5% of all adult admissions. Numerator: The number of Enrollees involuntarily admitted for mental health treatment to all inpatient settings regardless of whether the Contractor authorized or is funding the hospitalization, broken out by children (ages 0-17), and adults (ages 18+) Denominator: The number of Enrollees admitted for mental health treatment to all inpatient settings regardless of whether the Contractor is authorizing or is funding the hospitalization. Data Source: Authorizations.	
Standard	≤ 10% child admissions are involuntary ≤ 5% adult admissions are involuntary

10. Quality of Care: Inpatient Substance Abuse Treatment Readmission Rate of substance abuse inpatient readmission by Enrollee children and adults at 7, 30, and 90 days will be no higher than the following: 7-day readmission: Children 3.5%; Adults 5% 30-day readmission: Children 9%; Adults 13% 90-day readmission: children: 17%; Adults 24% Numerator: The number of Iowa Plan Enrollee inpatient readmissions within 7/30/90 days of discharge. Denominator: The number of Iowa Plan Enrollee inpatient discharges that occur within the reporting periods, less 7, 30 or 90 days. Data Source: Claims.			
Standard	7-day readmission children: 3.5% adults: 5%	30-day readmission children: 9% adults: 13%	90-day readmission children: 17% adults: 24%

11. Quality of Care: Readmission for Non-Inpatient Services

Rate of readmission by Iowa Plan eligible children and adults at 7, 30, and 90 days substance abuse residential III.3 and III.5 for which there are at least 30 discharges per month.

Numerator: The number of substance abuse residential readmissions within 7/30/90 days of discharge.

Denominator: The number of discharges that occur within the reporting periods, less 7, 30 and 90 days.

Data Source: Claims.

Standard	7-day readmission Monitor Only	30-day readmission Monitor Only	90-day readmission Monitor Only

12. Quality of Care: Antidepressant Medication Management

48% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on antidepressant medication for at least 84 days (12 weeks)

32% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on an antidepressant medication for at least 180 days (six months)

Numerator and Denominator: Utilize HEDIS 2009 specifications for the measure "Antidepressant Medication Management"

Data Source: Claims and Enrollment.

* The Contractor shall be responsible for generating these measures only after DHS has provided the Contractor with the pharmacy claims data necessary to calculate these measures. "Remained on" is based on a prescription refill.

Standard	48% of adult Enrollees remained on antidepressant medication for at least 84 days 32% of adult Enrollees remained on antidepressant medication for at least 180 days

13. Quality of Care: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

50% of Enrollees with alcohol or other drug dependence (AOD) initiate treatment through an AOD outpatient assessment (first diagnosis) and receive a follow up treatment service within 14 days of the diagnosis

75% of Enrollees with alcohol or other drug dependence (AOD), initiate treatment through an AOD outpatient assessment (first diagnosis) and receive a treatment service visits within 30 days of the diagnosis

Numerator: Number of enrollees with an initial SA assessment paid claim that has follow up treatment(s) within the time parameters indicated above.
Denominator: Number of enrollees with an initial SA assessment paid claim

Data Source: Claims.

Standard	50% of Enrollees receive a service within 14 days of the diagnosis 75% of Enrollees receive a service visits within 30 days of the diagnosis

14. Quality of Care: Outcome Measurement – Medicaid Adults and Older Adolescents

The Contractor shall support Medicaid adult Enrollees such that at least 50% of adults receiving Iowa Plan outpatient services report improvement in emotional health as reported by comparison of initial and most recent assessment using the Consumer Health Inventory (CHI).

Numerator: The total number of Enrollees, age 14 or older, that have at least 2 CHI scores with the most recent during the reporting period, where improvement is shown from the first to the most recent score.

Denominator: The total number of Enrollees, age 14 or older, that have at least 2 CHI scores with the most recent during the reporting period.

Data Source: CHI Outcomes Assessment Report

Standard	Report aggregate improvement from initial to follow up administration

15. Quality of Care: PCP Coordination

The Contractor shall measure the frequency with which network providers communicate with PCPs regarding Enrollees whom they are both treating.

Numerator: The number of randomly sampled network treatment records reviewed during the reporting period where communication between the network provider and PCP is documented to have occurred.
Denominator: The number of treatment records that were reviewed during the reporting period.

Data Source: Sampled Network Treatment Records.

Standard	More than 70% of Treatment Record Document Communication to the PCP

16. Quality of Care: Psychotropic Medication Screening

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

Standard	Monitor Only

17. Quality of Care: Return to the Community for Children in PMICS

The Contractor shall measure its performance in helping children return to the community by tracking average Iowa Plan Enrollee length of stay in PMICs for mental health services.

Numerator: The number of days of mental health stay in PMICs by Iowa Plan child and adolescent Enrollees
Denominator: The number of Iowa Plan child and adolescent Enrollees with a PMIC mental health stay

Data Source: - As reported by IME/Medical Services Quarterly

Standard	Monitor Only

18. Quality of Care: Treatment of the Dually Diagnosed

The Contractor shall increase the percentage of dually diagnosed Enrollees discharged from inpatient substance abuse and mental health treatment settings such that at least 75% of discharged Enrollees receive either a substance abuse or mental health service within 7 days of discharge.

Numerator: Dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting who received either substance abuse or mental health services within 7 days of discharge. Enrollees with both Medicaid and Medicare are excluded.

Denominator: Dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting. Enrollees with both Medicaid and Medicare are excluded.

Data Source: Authorizations, ICM Database, Claims Data.

Standard	75% receive MH or SA treatment follow-up within 7 days

19. Inpatient Concordance Rate - Initial

The Contractor shall monitor its performance in the rate of concordance with facility requests for inpatient mental health care. This will be for community-based facilities and will not include the state MHI's.

Numerator: The number of initial requests for mental health inpatient treatment that the contractor receives from facilities and authorizes a 24-hour level of care.

Denominator: The number of initial requests for mental health inpatient treatment that the contractor receives from facilities.

Data Source: Authorizations

Standard	Monitor Only

20. Quality of Care: Behavioral Health Assessment Aligned to BHIS services

In the second 6-month period of the first contract period, 75% of the BHIS clinical records reviewed will align the member's behavioral health diagnosis and symptoms/day to day impairments with the treatment goals. (QI Review of community and/or group care clinical records) (minimum of 120 charts annual with 60 in the last 6 month period)

Numerator: The number of BHIS clinical records reviewed, either community-based or group care, in which the behavioral health diagnosis and symptoms/day to day impairments were aligned with the client's treatment goals.
Denominator: The total number of BHIS community-based and group care clinical records reviewed.

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data source: chart review

	Baseline Period July 1 – December 31, 2012	January 1 – June 30, 2013
% with aligned goals		
Number of charts with aligned goals		
Number of charts reviewed		
Providers visited		
Standard	75% or more of all clinical records have goals aligned with behavioral assessment **Minimum of 120 charts (annual number)**	

21. Quality of Care: BHIS and Clinical Consult

By the end of the first contract period, 75% of the BHIS clinical records reviewed will show that the BHIS provider consulted at least quarterly with the practitioner who performed the assessment and/or the practitioner who is providing ongoing therapy.

Numerator: The number of BHIS clinical records reviewed, either community-based or group care which indicate at least quarterly consultation with either the practitioner that performed the assessment and/or the practitioner who is providing ongoing therapy.
Denominator: The total number of BHIS community-based and group care clinical records reviewed.

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data source: chart review

	2012		**2013**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% with BHIS and Clinical consult				
Number of charts with consult				
Number of charts reviewed				
Providers visited				
Standard	By year's end 75% or more of all clinical records have BHIS and Clinical Consult **Minimum of 120 charts (annual number)**			

PERFORMANCE INDICATORS
IOWA PLAN FOR BEHAVIORAL HEALTH
PMIC Monitoring Only
July 1, 2012 – June 30, 2013

1. Quality of Care: Return to the Community for Children in PMICs - ALOS

The Contractor shall measure its performance in helping children return to the community by tracking average Iowa Plan Enrollee length of stay in PMICs for mental health services.

Numerator: the number of days of mental health stay in PMICs by Iowa Plan child and adolescent Enrollees

Denominator: the number of Iowa Plan child and adolescent Enrollees with a PMIC mental health authorization

Data source: Authorizations

	2012		2013	
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
0-12 year olds # of days				
13-17 year olds # of days				
18+ # of days				
Overall				

Note: the data are reported quarterly with a one month lag.

2. Quality of Care: PMIC Readmission

Rate of PMIC readmission 30, 60, and 90 days.

Numerator: the number of PMIC readmissions within 30, 60, and 90 days of discharge*

Denominator: the number of PMIC discharges that occur within the reporting periods, less 90/180 days*

Data source: Authorizations; Exclude PMIC to PMIC transfer for clinical reasons

	2012						2013					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
30-day readmission												
0-12												
13-17												
Overall												
60-day readmission												
0-12												
13-17												
Overall												
90-day readmission												
0-12												
13-17												
Overall												

	30-day readmission	60-day readmission	90-day readmission
Standard	*Set baseline* (monitor only)	*Set baseline* (monitor only)	*Set baseline* (monitor only)
Contract Period to Date	0-12: % 13-17: % Overall: %	0-12: % 13-17: % Overall: %	0-12: % 13-17: % Overall: %

3. Quality of Care: PMIC Discharge Plan Documented

A discharge plan shall be documented within 30 days of admission for Enrollees being admitted to a PMIC setting. The discharge plan shall include, at a minimum: 1) anticipated length of stay, 2) initial identification of family and community supports or resources, and 3) if applicable, restrictions on activities and when the Enrollee can return to work or school, including the school setting.

Numerator: the number of Enrollees* who have been discharged from a PMIC setting for whom a discharge plan was documented in the record within 30 days of admission.

Denominator: the number of Enrollees* discharged from a PMIC setting

Note: this measure excludes Enrollees who left treatment against medical advice

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

Data source: retrospective chart reviews

	2012		2013	
	Quarter to Date (Jul-Sep)	Quarter to Date (Oct-Dec)	Quarter to Date (Jan-Mar)	Quarter to Date (Apr-Jun)
% with d/c plan documented	%	%	%	%
Number of charts with d/c plan documented				
Number of charts reviewed				
Providers visited				
Contract Period to Date	% with d/c plan documented: % Number of charts with d/c plan documented: Number of charts reviewed: Providers visited:			
Standard	Set baseline For documented discharge plans at discharge			

**Measure will be collected starting January 1, 2012. This will allow for a six month transition period, during which, training or needs for training will be identified.

4. Quality of Care: Implementation of PMIC Discharge Plans

Measure the percent of all discharge plans written for Enrollees being released from a PMIC shall be implemented . The discharge plan shall include, at a minimum: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) if applicable, restrictions on activities and when the Enrollee can return to work or school, including the school setting.

Numerator: number of Enrollees* who have been discharged from a PMIC setting during the contract period (whether or not the PMIC admission was authorized by the Contractor at the time of discharge) for whom claims data or provider records reflect implementation of the follow-up plan written with the Enrollee at the time of discharge

Denominator: number of Enrollees* who have been discharged from a PMIC setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge)

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement

Data source: chart review; exclude ASA discharges, out of state relocation or transfers to a legal institution

	Contract Period to Date
% with discharge plan implemented	%
Number of charts with d/c plan implemented	
Number of charts reviewed	
Providers visited	
Standard	Set baseline of all discharge plans implemented

**Measure will be collected starting January 1, 2012. This will allow for a six month transition period, during which, training or needs for training will be identified.

5. Quality of Care: PMIC Discharges to desired living arrangement

Monitor the percent of Enrollees who were discharged from a PMIC setting to desired living arrangement *.

Numerator: the number of Enrollees who were discharged to home* from a PMIC setting

Denominator: the number of Enrollees who were discharged from a PMIC setting

Note: "Desired living arrangement" is defined as the resident of the parent, adoptive parent, guardian, or for minors in the custody of the DHS as identified in the permanency plan. Categories of home are: client home, foster home, and relative/friend home.

Data source: Authorizations Exclude ASA discharges, out of state relocation or transfers to a legal institution

	2012		2013	
	Quarter to Date (Jul-Sep)	Quarter to Date (Oct-Dec)	Quarter to Date (Jan-Mar)	Quarter to Date (Apr-Jun)
% of children	%	%	%	%
Standard	Set baseline			

6. Consumer Involvement and Quality of Life: Consumer Satisfaction Surveys

The Contractor shall conduct a biannual Iowa Plan Eligible Person experience of care survey that assesses experience of care with youth receiving PMIC services.

- The survey instruments shall be standardized, validated tools approved by the Departments and shall address areas recommended by the Recovery Advisory Committee.
- The number of surveys distributed shall represent at least the minimum number required to comprise a statistically valid sample of those Iowa Plan Eligible Persons who have accessed PMIC services in the past six months.
- The acceptable response rate shall be determined by DHS, in consultation with the Contractor.
- Results shall be reported to Iowa Plan Eligible Persons as well as corrective actions implemented in response to findings of the surveys.

Progress to Date	
Standard	Consumer Surveys conducted twice per contract year and results reported

7. Based on the annual Eligible Person experience of care survey, 85% of respondents indicate satisfaction with services provided by the Iowa Plan.	
Progress to Date	
Standard	85% or more

8. Consumer Involvement and Quality of Life: PMIC and Family Involvement

By the end of the first contract period, monitor the percent of records reviewed that demonstrate the member's parent or caregiver participated twice a month in one or more of the following treatment activities; the comprehensive behavioral health assessment, development of the individual treatment plan, communication regarding day to day treatment interventions, applying PMIC interventions to home and other community environments, regular treatment plan evaluations, and discharge planning.

Numerator: The number of PMIC clinical records reviewed, which indicate at least every two week involvement with the member's parent or caregiver

Denominator: The total number of PMIC records reviewed.
*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period. DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Excludes: Children of families whose parental rights are terminated and no guardian has been identified.
Data source: chart review

	2012		2013	
	Quarter to Date (Jul-Sep)	Quarter to Date (Oct-Dec)	Quarter to Date (Jan-Mar)	Quarter to Date (Apr-Jun)
% with family involvement				
Number of charts with family involvement				
Number of charts reviewed				
Providers visited				
Standard	Set baseline of family involvement			

Note: the data are reported quarterly with a one month lag.