

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

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

Facesheet

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

The **State of Iowa** requests a waiver/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 Plan. (Please list each program name if the waiver authorizes more than one program.)

Type of request. This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part _____
 - 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/renewal/amendment is requested for a period of 2 years; effective July 1, 2007 and ending June 30, 2009. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Cynthia Tracy and can be reached by telephone at (515) 725-1145, or fax at (515)-725-1010, or e-mail at CTracy@dhs.state.Ia.us. (Please list for each program)

Section A:

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.

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

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Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

II. Details of Monitoring Activities

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

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

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

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

- NCQA
- JCAHO
- AAAHC
- Other** (please describe)

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The contractor was required to be accredited as a prerequisite to winning the competitive procurement and is required to maintain accreditation.
- **Frequency of use:** The accreditation must be in force for the duration of the contract.
- **How it yields information about the area(s) being monitored:** Magellan must provide proof of accreditation to the State. State uses the accreditation as a proxy measure for quality of care.

Accreditation for Participation is used to monitor:

- Program Integrity
- Quality of Care

c. X

Consumer Self-Report data

 CAHPS (please identify which one(s))

 X **State-developed survey**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:**
 - a) **Monitoring Performance Indicator #2: Consumer Satisfaction Survey**
 Goal: Consumer satisfaction surveys shall be conducted at least two times over contract period.
 - b) **Monitoring Performance Indicator #3: Consumer Satisfaction Survey (Also QI Workplan: Member Satisfaction)**
 Goal: ≥85% of respondents will indicate some degree of satisfaction with services provided by the Iowa Plan.
 The survey instrument was developed by Magellan with input from the Consumer/Family Member/Advocate Roundtable and the Quality Improvement (QI) Committee. The survey instrument was approved by the State. Survey results are reported and reviewed by the QI Committee, which includes consumer and family representatives as well as the State. The survey instrument and results are included in Magellan's QI Workplan, QI Quarterly Reports, and QI Annual Report (which serves as the annual Iowa Plan quality evaluation) and are reviewed as part of the External Quality Review process.
- **Frequency of use:** The Client Satisfaction Survey process is done twice each contract year. The sample for each survey is drawn from Iowa Plan Medicaid enrollees who received a covered service in the previous six months and who have not been surveyed before.
- **How it yields information about the area(s) being monitored:** Client Satisfaction Survey information is used to monitor:
 - Information to Beneficiaries
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

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

quality improvement processes and to improve consumer information for member use.

Disenrollment survey

X

Consumer/beneficiary focus groups

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

Focus groups foster communication and improvement of plan operations by providing stakeholders with plan information and soliciting feedback from impacted stakeholders. The information gathered is integrated into quality improvement processes, as indicated. Focus groups provide information regarding the effectiveness of the Iowa Plan and assist in the identification of strengths and weaknesses. Information is obtained from members both in terms of questions or topic areas that are presented to them and in terms of the questions or concerns members may raise separate from a meeting's agenda.

Advisory Committee and Roundtable members receive responses to any questions or concerns they raise.

d. X

Data Analysis (non-claims)

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

___ Denials of referral requests

___ Disenrollment requests by enrollee

___ From plan

___ From PCP within plan

X **Grievances and appeals data**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Grievance and Appeal information is included in monthly and annual QI reporting and is reviewed at least quarterly by the QI Committee. Specific performance measures address Grievances and Appeals including:
 - a) **Penalty Performance Indicator #9: Appeals Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)**
Goal: $\geq 95\%$ of appeals resolved within 14 calendar days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial 14 day period.
 - b) **Penalty Performance Indicator #10: Expedited Appeal Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)**
Goal: $\geq 95\%$ of expedited appeals resolved within three working days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial three day period.
 - c) **Penalty Performance Indicator #11: Grievance Reviews (Also QI Workplan: Percent of Grievances that met Turn-around Time Standard))**
Goal: $\geq 95\%$ of grievances resolved within 14 calendar days; 100% resolved within 90 calendar days.
 - d) **QI Workplan: Grievance Responsiveness - Grievances per 1000**
Goal: $\leq .5/1000$ members
 - e) **QI Workplan: Grievance Responsiveness - Mean time to Grievance Resolution**

- f) QI Workplan: Appeals Responsiveness - Percent of Appeals that led to Overturn of UM Decision
- g) QI Workplan: Member Requests Change of Provider
- **Frequency of use:** Data are gathered and reported monthly and quarterly with quarterly review by the QI Committee, at a minimum.
- **How it yields information about the area(s) being monitored:** Grievance and Appeal data are used to monitor:
 - Program Integrity
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Provider Selection
 - Quality of Care

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

PCP termination rates and reasons

X **Other** (please describe)

Reporting

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Numerous Iowa Plan requirements are monitored through analysis of non-claims data.

Examples include:

- a) Incentive Performance Indicator #2: Consumer Involvement
Goal: Magellan shall arrange/participate in 450 Joint Treatment Planning Conferences per contract year with the member present in $\geq 97\%$ of the conferences.
- b) Penalty Performance Indicator #1: Consumer Involvement
Goal: New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name is provided to Magellan; 95% in 10 working days, 100% in 15 working days
- c) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
- d) Penalty Performance Indicator #7: Quality of Care

Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.

- e) QI Workplan: Membership - Total of all Medicaid Enrolled Clients
- f) QI Workplan: Critical Incident and QI Occurrence Reporting - Total Number of Critical Incidents Reported
- g) QI Workplan: Clinical Practice Guidelines Educate providers on Clinical Practice Guidelines and encourage compliance.
- **Frequency of use:** While ad hoc reporting and analysis can be done as indicated, most analysis is linked to data gathered on a monthly basis for the QI Workplan and Iowa Plan Performance Indicators and is reported monthly and quarterly to the State.
- **How it yields information about the area(s) being monitored:** Non-claims data are used to monitor:
 - Enrollment/Disenrollment
 - Information to Beneficiaries
 - Timely Access
 - Specialist Capacity
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of CareInformation is reviewed and analyzed as part of Magellan's QI processes to identify trends and sentinel or adverse events. The data and findings are reported to Magellan's QI Committee and the State. Committee members discuss findings to identify opportunities for improvement.

e. X

Enrollee Hotlines operated by State

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan has staff on-site in their Iowa office available by 800 phone number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls range from non-urgent requests for referral to behavioral health crises. The 800 number (1-800-317-3738) is printed on Iowa Plan enrollee Medicaid cards and is published in the Iowa Plan Client Handbook and associated materials. The Client Handbook is included in the documents sent by Magellan to new enrollees. This information is also part of the annual notification to all Iowa Plan enrollees and is available whenever requested.
- **Frequency of use:** The 800 number is available 24 hours a day, every day.

- **How it yields information about the area(s) being monitored:** The client 800 # is used to monitor:
 - Information to Beneficiaries
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

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

f. X

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

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Focused Studies are conducted as indicated to monitor and intervene as necessary with operational or quality issues or trends. Generally, in minutes and other documentation, Magellan defines Focused Studies as Performance Measures. These are separate and distinct from Performance Indicators as described in the Performance Measures sections of the waiver application.
- **Frequency of use:** Focused Studies/Performance Measures are initiated as indicated by data or as identified or recommended by Magellan staff, the State, QI Committee members, or other stakeholders. Such studies generally run for two - three months. If analysis of a Focused Study/Performance Measure identifies significant improvement opportunities or suggests formal interventions are needed, a Performance Improvement Project may be initiated.
- **How it yields information about the area(s) being monitored:** Focused Studies/Performance Measures are used to monitor:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

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

reported to the State. Committee members discuss findings to identify opportunities for improvement. Information and analysis aids in the assessment of the effectiveness of quality improvement processes.

g. X

Geographic mapping of provider network

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:**
 - a) Network Status Report
Geographic mapping is done through Geo Access reporting which shows distribution of provider types across the state. Information is submitted to the State in Network Status reports. Reports have the capability of mapping provider locations in Iowa. Examples of provider types shown through Geo Access reporting include psychiatrists, psychologists, social workers, and group practices.
 - b) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
 - c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes;
Rural: Inpatient - 45 miles, Outpatient - 34 miles
 - d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
- **Frequency of use:** Network Status reports are submitted as part of the QI Quarterly Report package. Performance Indicators and QI Workplan measures are discussed monthly by the QI Committee and are submitted as part of the QI Quarterly Report.
- **How it yields information about the area(s) being monitored:**

Provider geographic information is used to monitor:

 - Timely Access
 - PCP/Specialist Capacity

Provider geographic information is analyzed for compliance with access and capacity requirements. The analysis is part of the QI Workplan and is reported to Magellan's QI Committee and to the State. Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted, Magellan conducts corrective action until compliance is met.

h. NA

Independent Assessment of program impact, access, quality, and

cost-effectiveness (**Required** for first two waiver periods)

i. X

Measurement of any disparities by racial or ethnic groups

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan initiated a Performance Improvement Project during the 2005-06 contract year to support development of culturally-specific outpatient substance abuse services in Des Moines. The PIP was based on data related to access by different racial/ethnic groups that suggested black/African American enrollees had lower rates of use of outpatient substance abuse services as compared to more intensive services. PIP development was consistent with focused discussion by the Iowa Plan Advisory Committee.
- **Frequency of use:** The PIP will be implemented for at least two years.
- **How it yields information about the area(s) being monitored:**
Measurement of Disparity will monitor:
 - Timely Access
 - Coordination/ContinuityThe PIP will provide information on general enrollee use of services before and after initiation of culturally specific services as a service option in the Des Moines area.

j. X

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

 X **Network Reports**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Magellan submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.
 - a) Network Status Report
Information is submitted to the State in Network Status reports. Examples of provider types reviewed include psychiatrists, psychologists, social workers, and group practices.
 - b) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen

within 48 hours of reporting symptoms; routine services within four weeks of the request.

- c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes; Rural: Inpatient - 45 miles, Outpatient - 34 miles
- d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
- e) QI Workplan: Network Adequacy - Density
The number of providers per 1000 members.
- **Frequency of use:** Documentation was submitted at the time of contracting and is submitted any time there is a significant change that would affect adequate capacity and services or at enrollment of a new population. Network Status and Performance Indicator reports are submitted quarterly as part of the QI Quarterly Report package. QI Workplan reports are submitted monthly as part of the materials for the QI Committee and are included in the QI Quarterly Report. Performance Indicator and QI Workplan reports are also included in the QI Annual Report.
- **How it yields information about the area(s) being monitored:** Network reports provide information on:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of CareData are used to: 1) develop a quantitative understanding of the service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. Analysis results become part of the QI Workplan and are reported to Magellan's QI Committee and the State. Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. If indicated, Magellan implements corrective action through QI processes, including focused studies/Performance Measures.

X Other - Credentialing

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The credentialing/contracting process includes consideration of provider qualifications for the Iowa Plan network. Credentialing activities are under the purview of

Magellan's Professional Provider Review Committee, a subcommittee to the QI Committee.

a) **Penalty Performance Indicator #12: Network Management**
(Also QI Workplan: Timeliness of Credentialing and Re-Credentialing)

Goal: Credentialing of Iowa Plan providers shall be completed as follows: 60% in 30 days, 100% in 90 days.

- **Frequency of use:** Credentialing is one step in a prospective provider's contracting process with Magellan for the Iowa Plan. Re-credentialing is done with existing providers every three years. Credentialing review may also be done based on provider-specific considerations.
- **How it yields information about the area(s) being monitored:** Credentialing monitors information related to :
 - Timely Access
 - Coverage/Authorization
 - Provider Selection
 - PCP/Specialist Capacity
 - Quality of Care

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

X **Clinical On-Site Review**

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

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

a) **Incentive Performance Indicator #8: Quality of Care**

Goal: $\geq 90\%$ of all discharge plans written for enrollees discharged from mental health inpatient shall be implemented; with ≥ 185 records reviewed.

- b) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
- c) Penalty Performance Indicator #7: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.
- d) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
- e) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
- f) QI Workplan: Clinical Practice Guidelines
Educate providers on Clinical Practice Guidelines and encourage compliance.
- g) QI Workplan: Retrospective Treatment Record Reviews - Percent Compliance with Tool

- **Frequency of use:** Clinical on-site review is conducted annually, at a minimum. Additional focused reviews may be conducted as part of follow-up to a corrective action plan requirement, based on the recommendation of the Professional Provider Review Committee, or because of quality or contractual indicators.
- **How it yields information about the area(s) being monitored:** Clinical on-site review information is used to monitor:
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

As a result of on-site monitoring, Magellan offers education and technical assistance to providers. Magellan must offer orientation and on-going training to network providers at least two times per year. Technical assistance is done with specific

providers or provider groups based on their request or an identified need through an on-site review or other monitoring.

k. NA Ombudsman

l. X On-site review

X External Quality Review

- **Applicable program:** PIHP
- **Personnel responsible:** External entity identified by State, currently the Iowa Foundation for Medical Care.
- **Detailed description:** External Quality Review is a process by which an External Quality Review Organization, through a specific agreement with the State, reviews and evaluates Magellan policies and processes implemented for the Iowa Plan. External Quality Reviews include extensive review of Magellan documentation and interviews with Magellan staff. Interviews with Iowa Plan stakeholders and confirmation of data may also be conducted.
- **Frequency of use:** External Quality Review is done annually.
- **How it yields information about the area(s) being monitored:** External Quality Review provides monitoring information related to:
 - Information to Beneficiaries
 - Grievance
 - Timely Access
 - Coordination/Continuity
 - Coverage/Authorization
 - Quality of Care

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

m. X Performance Improvement Projects [Required for MCO/PIHP]

X Clinical

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** As stated in the Iowa Medicaid Managed Care Quality Assurance System document, the Contractor must conduct Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurement and intervention, significant improvement,

sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

- **Frequency of use:** Two new Performance Improvement Projects are implemented each contract year. The status of each project is reported to the State each quarter.
- **How it yields information about the area(s) being monitored:** Performance Improvement Projects provide monitoring information related to:
 - Timely Access
 - Coordination/Continuity
 - Quality of Care

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

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

___ Non-clinical

n. X

Performance measures [Required for MCO/PIHP]

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

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** The State has established a comprehensive listing of performance measure areas, entitled Performance Indicators, for Magellan's implementation of the Iowa Plan. In addition to Performance Indicators, cost of care data are summarized for each Plan capitation cell as part of the Magellan Iowa Plan reporting package to the State. Annual audits address financial considerations.
- **Frequency of use:** Performance Indicators are included on the QI Workplan reviewed monthly in the QI Committee. A year-to-date Performance Indicators report is submitted as part of the QI Quarterly

and Annual reports. Other data reporting is done each month. Audits are done each year.

- **How it yields information about the area(s) being monitored:**

Performance measures provide information related to:

- Information to Beneficiaries
- Grievance
- Timely Access
- Coordination/Continuity
- Coverage/Authorization
- Quality of Care

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

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

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

X **Provider Profiling**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Provider Profiling documents provider-specific performance on key elements of the Iowa Plan and aggregates such data for comparison review and to identify outliers.
- **Frequency of use:** Provider Profiling is generated and distributed each quarter.
- **How it yields information about the area(s) being monitored:** Provider Profiling offers information for monitoring:
 - Coordination/Continuity
 - Coverage/Authorization

Each provider gets a copy of its specific report as well as the aggregate report. The aggregate report is used by the State and Magellan to identify of opportunities for quality improvement or technical assistance.

X **Provider Medication Monitoring**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan; Drug Utilization Review Commission
- **Detailed description:** Magellan works with the Drug Utilization Review Commission to understand and monitor

prescribing of psychotropic medications, including monitoring for potential changes in overall utilization by those enrolled in the Iowa Plan.

a) **Monitoring Performance Indicator #21: Psychotropic Medication**

Goal: Magellan shall screen all client admitted to inpatient for psychotropic medication use. If the medication is not appropriate, intervention will be made with the prescribing doctor.

- **Frequency of use:** Monitoring activities are reported in the QI Quarterly Report.
- **How it yields information about the area(s) being monitored:** Provider medication monitoring provides information related to:
 - Coordination/Continuity
 - Quality of CarePerformance Indicator data are reported monthly in the QI Workplan and are reviewed each month by the QI Committee. A Performance Indicator report is also included in the QI Quarterly Report and the QI Annual Report. Analysis is part of the QI Workplan and is reported to Magellan's QI Committee and to the State. Committee members discuss the findings to identify opportunities for improvement. Magellan initiates QI processes as indicated.

q. X

Provider Self-report data

X **Survey of Providers**

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Administration no less than annually of a provider satisfaction survey.
 - a) **Monitoring Performance Indicator #16: Provider Satisfaction Survey (Also QI Workplan: Provider Satisfaction)**

Goal: Magellan will conduct an annual provider survey in which $\geq 75\%$ of network providers responding indicate satisfaction.
- **Frequency of use:** The Provider Satisfaction Survey is distributed each year.
- **How it yields information about the area(s) being monitored:**
 - Timely Access
 - Coordination/Continuity
 - Quality of CareResults are reviewed in the QI Committee and are included in QI Quarterly and Annual reports. The survey process and

results are also reviewed through the annual External Quality Review process. If areas for improvement are noted, Magellan incorporates identified issues into QI processes.

X Focus Groups

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

- input on quality assurance and performance improvement projects

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

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

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

- **Applicable program:** PIHP
- **Personnel responsible:** Contractor/Magellan
- **Detailed description:** Utilization review is the process by which Magellan monitors all clinical activities and associated data, including authorization/non-authorization of services and encounter data.
 - a) Incentive Performance Indicator #1: Readmission Rate (Also QI Workplan: 30-Day Readmission)
Goal: $\leq 15\%$ of enrollees discharged from mental health inpatient readmit to inpatient within 30 days of discharge
 - b) Incentive Performance Indicator #4: Involuntary Hospitalization
Goal: The percent of involuntary admission to mental health inpatient shall not exceed 15% for children and 10% for adults.
 - c) Incentive Performance Indicator #5: Service Array
Goal: At least 6% of mental health service expenditures will be used in the provision of integrated services and supports.
 - d) Incentive Performance Indicator #6: Quality of Care (Also QI Workplan: 7-Day Ambulatory Follow-up)
Goal: $\geq 90\%$ of persons discharged from mental health inpatient will receive other treatment services in seven days.
 - e) Incentive Performance Indicator #7: Quality of Care
Goal: $> 60\%$ of enrollees discharged from ASAM Levels III.5 and III.3 receive a follow-up substance abuse service in 14 days.
 - f) Penalty Performance Indicator #4: Quality of Care
Goal: $\geq 95\%$ of enrollees who received services in an emergency room and for whom inpatient was requested but not authorized shall have a follow-up contact in three business days of the date Magellan is notified of the ER service.
 - g) Monitoring Performance Indicator #18: Dual Diagnosis
Goal: Magellan will identify dually diagnosed clients admitted to inpatient or residential and track the follow-up services received.
 - h) Monitoring Indicator #19: Emergency Room
Goal: Magellan will monitor the number and percentage of clients presenting to the emergency room who had a service 30 days prior.
 - i) Monitoring Indicator #22: Quality of Care - Treatment of the Dually Diagnosed (Also QI Workplan: Dual Diagnosis Enrollee Follow-up)

Goal: 40% of dually diagnosed enrollees discharged from inpatient receive both mental health and substance abuse services in seven working days.

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

k) QI Workplan: Clinical Authorizations per 1,000

- **Frequency of use:** Data related to utilization review are reported in the QI Quarterly Report and are reviewed by the QI Committee.

- **How it yields information about the area(s) being monitored:**

Utilization review data can be used to monitor:

- Program Integrity
- Grievance
- Timely Access
- Coordination/Continuity
- Coverage/Authorization
- Quality of Care

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

t. NA

Other: (please describe)

Section C: Monitoring Results

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

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

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

This is a renewal request.

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

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

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

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

NCQA

JCAHO

AAAHC

Other (please describe)

- **Strategy:** Magellan must be accredited.
- **Confirmation:** X Yes
- **Summary of results:**

Magellan's Iowa office was accredited by URAC June 2002-June 2004 and was re-accredited June 2004-June 2007. Strengths identified in Magellan's 2004 URAC re-accreditation summary report included:

 - the inclusion and participation of customers on committees
 - implementation of quality reviews with high volume facilities
 - use of field Intensive Care Managers and flexible scheduling for care managers
- **Problems identified:** URAC made no formal recommendations for follow-up in Magellan's last two accreditation processes. The following opportunities for improvement were identified in the 2004 re-accreditation summary report:
 - stronger collaboration with customers regarding Magellan's Intensive Care Management (ICM) program
 - greater standardization and continued enhancement of the ICM program, including the development of acuity guidelines for caseload determination
 - review of non-authorization letters and other communications to prevent typos and wrong dates and to improve quality
- **Corrective action** (plan/provider level): On-going State review of non-authorization and appeal correspondence was initiated and continues.
- **Program change** (system-wide level): Magellan implemented Intensive Care Management (ICM) for the Iowa Plan in July 2004. All Iowa Plan enrollees are eligible for participation in ICM which emphasizes recovery and consumer-directed service planning and delivery. ICM was presented to the Iowa Plan Advisory Committee, the Clinical Advisory Committee, the Consumer/Family Advisory Committee, and Provider Roundtables. Through these and other forums, Magellan provided education to consumers and families and technical assistance to providers to foster the State's desired

recovery/empowerment approach to mental health service delivery under the Iowa Plan. Updates on ICM are presented to stakeholders.

c. X

Consumer Self-Report data

 X **State-Developed Survey**

- **Strategy:** Magellan distributes consumer satisfaction surveys twice each year.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Monitoring Performance Indicator #2: Consumer Satisfaction Survey
Goal: Consumer satisfaction surveys shall be conducted at least two times over contract period.
Magellan Performance (August 2006 QI Annual Report): Surveys were distributed in February and April 2006.
 - b) Monitoring Performance Indicator #3: Consumer Satisfaction Survey (Also QI Workplan: Member Satisfaction)
Goal: ≥85% of respondents will indicate some degree of satisfaction with services provided by the Iowa Plan.
Magellan Performance (August 2006 QI Annual Report):
February 2006 - 89.7% Adult, 87.9% Child/Adolescent
February 2006 - 89.9% Adult, 87.4% Child/Adolescent
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

 X **Consumer/Beneficiary Focus Groups**

- **Strategy:** Magellan holds regularly scheduled meetings for consumer/beneficiary input into the Iowa Plan.
- **Confirmation:** X Yes
- **Summary of results:** Magellan held quarterly Consumer/Family Advisory Committee meetings and Children's Mental Health Stakeholders Roundtable meetings during the 2004-05 and 2005-06 Iowa Plan contract years. The meetings addressed Iowa Plan issues from consumer, family member, and advocate perspectives.
Agenda items have included:
 - overview of the Iowa Plan
 - roles and responsibilities of the Advisory Committee, including review of Magellan's annual Iowa Plan Quality Assessment and Performance Improvement Plan; input on annual Iowa Plan QI Goals; review of Magellan's year-end QA Plan and Performance Indicators performance; feedback on operational issues experienced by consumers,

family members, and/or providers; and input on potential areas for service development or service improvement

- updates on Iowa Plan activities
- updates by attendees
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

d. X

Data Analysis (non-claims)

X **Grievance and Appeal Data**

- **Strategy:** Magellan analyzes and reports grievance and appeal data.
- **Confirmation:** X Yes
- **Summary of results:** Examples of results, as documented in the August 2006 QI Annual Report, are as follows:
 - a) **Penalty Performance Indicator #9: Appeals Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)**
Goal: $\geq 95\%$ of appeals resolved within 14 calendar days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial 14 day period.
Magellan Performance (August 2006 QI Annual Report): 95.8% resolved in 14 calendar days. 100% of extended reviews resolved in additional 14 calendar days.
 - b) **Penalty Performance Indicator #10: Expedited Appeal Reviews (Also QI Workplan: Percent of Appeals which met Time Standard for Review)**
Goal: $\geq 95\%$ of expedited appeals resolved within three working days; 100% resolved within 45 calendar days with $\geq 95\%$ of extended reviews resolved within 14 calendar days from the end of the initial three day period.
Magellan Performance (August 2006 QI Annual Report): 100% resolved in three working days.
 - c) **Penalty Performance Indicator #11: Grievance Reviews (Also QI Workplan: Percent of Grievances that met Turn-around Time Standard))**
Goal: $\geq 95\%$ of grievances resolved within 14 calendar days; 100% resolved within 90 calendar days.
Magellan Performance (August 2006 QI Annual Report): 100% resolved in 14 calendar days.
 - d) **QI Workplan: Grievance Responsiveness - Grievances per 1000**
Goal: $\leq .5/1000$ members
Magellan Performance (August 2006 QI Annual Report): .08 grievances per 1000 members

- e) QI Workplan: Grievance Responsiveness - Mean time to Grievance Resolution
Magellan Performance (August 2006 QI Annual Report):
1 working day
- f) QI Workplan: Appeals Responsiveness - Percent of Appeals that led to Overturn of UM Decision
Magellan Performance (August 2006 QI Annual Report):
26.5%
- g) QI Workplan: Member Requests Change of Provider
Magellan Performance (August 2006 QI Annual Report):
0 requests received
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X Other - Reporting

- **Strategy:** Magellan analyzes and reports on a large variety of non-claims data.
- **Confirmation:** X Yes
- **Summary of results:** Magellan delivered reports as required for the 2004-05 and 2005-06 Iowa Plan contract years. In general, Performance Indicator thresholds and other contract requirements were met. Examples of results from the August 2006 QI Annual Report include:
 - a) Incentive Performance Indicator #2: Consumer Involvement
Goal: Magellan shall arrange/participate in 450 Joint Treatment Planning Conferences per contract year with the member present in $\geq 97\%$ of the conferences.
Magellan Performance (August 2006 QI Annual Report):
589 Joint Treatment Planning Conferences were conducted. 100% had consumer involvement.
 - b) Penalty Performance Indicator #1: Consumer Involvement
Goal: New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name is provided to Magellan; 95% in 10 working days, 100% in 15 working days
Magellan Performance (August 2006 QI Annual Report):
Three quarters were at 100% in 10 working days. One mailing was out of compliance in July 2005, putting that quarter at 90.7% in 10 working days.
 - c) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.

Magellan Performance (August 2006 QI Annual Report):
99%

- d) Penalty Performance Indicator #7: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.

Magellan Performance (August 2006 QI Annual Report):
97.9%

- e) QI Workplan: Membership - Total of all Medicaid Enrolled Clients

Magellan Performance (August 2006 QI Annual Report):
Enrollment ranged from a low of 272,115 to a high of 283,978 for the months in the July 2005 - June 2006 contract year.

- f) QI Workplan: Critical Incident and QI Occurrence Reporting - Total Number of Critical Incidents Reported
Magellan Performance (August 2006 QI Annual Report):
788 Critical Incidents

- g) QI Workplan: Clinical Practice Guidelines
Educate providers on Clinical Practice Guidelines and encourage compliance.

Magellan Performance (August 2006 QI Annual Report):
Magellan has eight behavioral health Clinical Practice Guidelines publications that are shared with providers and are available at MagellanHealth.com.

- **Problems identified:** Magellan did not meet the established performance threshold on Penalty Performance Indicator #1 for the 2005-06 contract year because one mailing to new enrollees in July 2005 was not made in 10 working days.
- **Corrective action** (plan/provider level): Magellan created a daily report to monitor mailings that is reviewed by the Iowa Director of Operations and Senior Report Analyst.
- **Program change** (system-wide level): Not applicable

e. X

Enrollee Hotline Operated by State

- **Strategy:** Magellan's Des Moines office is staffed by behavioral health clinicians 24 hours a day, 365 days a year. The toll-free 800 number is printed on enrollee Medicaid cards.
- **Confirmation:** X Yes
- **Summary of results:** Calls related to clinical needs were handled by Magellan care management staff. Referral information was made available as requested. Grievance calls were responded to by appropriate staff and entered into the grievance process.

- a) QI Workplan: Timeliness of Telephone Access - Average Speed of Answer
Goal: ≤30 seconds

Magellan Performance (August 2006 QI Annual Report): Clinical Care Teams - 17 seconds; Client/Provider Services - 19 seconds

- b) QI Workplan: Call Abandonment - Call Abandonment Rate
Goal: $\leq 5\%$

Magellan Performance (August 2006 QI Annual Report): Clinical Care Teams - 3.9%; Client/Provider Services - 4.7%

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

f. X

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

- **Strategy:** Magellan initiates focused studies through Performance Measures to address operational or quality issues or trends.
- **Confirmation:** X Yes
- **Summary of results:** Magellan conducted seven different Performance Measures in 2006:
 - a) Critical Incident Reports - Suicide Data (March 2006)
 - b) Inpatient Facility Safety Survey (September 2006)
 - c) Outpatient Penetration Rate (December 2006)
 - d) Readmission Study - Average Length of Stay (February 2006)
 - e) Readmission Study - Most Frequent Diagnoses (February 2006)
 - f) Schizophrenia Readmissions (October 2006)
 - g) Young Children Data (August 2006)
- **Problems identified:** Each Performance Measure (Focused Study) was initiated based on review of standard report data or from a question raised by the Quality Improvement Committee.
 - a) Critical Incident Reports - Suicide Data
Results: Critical Incident reporting may not full represent suicides among Iowa Plan members, in part, because reporting is done only for those members currently receiving behavioral health services
 - b) Inpatient Facility Safety Survey (September 2006)
Results: Individuals responding to Magellan's inpatient safety survey were not the provider staff most knowledgeable about behavioral health services.
 - c) Outpatient Penetration Rate (December 2006)
Results: Iowa Plan utilization rates for the 2005-2006 contract year were consistent with rates for the previous year and for similar behavioral health plans. No further action was recommended.
 - d) Readmission Study - Average Length of Stay (February 2006)
Results: The average length of stay for members admitted to mental health inpatient was 4.6 days. The average length of stay

for those members readmitted to inpatient mental health 30 days post-discharge from inpatient was 7.38 days. No further action was recommended.

- e) Readmission Study - Most Frequent Diagnoses (February 2006)
Results: The most prevalent diagnoses for members receiving inpatient services were Depression, Schizophrenia, and Bipolar Disorder. No further action was recommended.
- f) Schizophrenia Readmissions (October 2006)
Results: Individuals with a Schizophrenia diagnosis represent a sample of Iowa Plan members for whom specific interventions could reduce inpatient readmissions.
- g) Young Children Data (August 2006)
Results: The utilization rate for Iowa Plan children is not higher than comparative populations. No further action was recommended.
- **Corrective action** (plan/provider level):
 - Critical Incident Reports - Suicide Data
Magellan will continue to remind providers to report Critical Incidents and use Provider Roundtables as one reminder method.
 - Inpatient Facility Safety Survey (September 2006)
Magellan staff recommended specific provider staff to receive future patient safety surveys. Survey responses will be reviewed as part of the standard credentialing process.
 - Schizophrenia Readmissions (October 2006)
Members with a Schizophrenia diagnosis are invited to participate in Magellan's Intensive Care Management program. (See the Intensive Care Management Performance Improvement Project.)
- **Program change** (system-wide level):
 - Critical Incident Reports - Suicide Data
Magellan will remind providers to report Critical Incidents.

g. X

Geographic Mapping of Provider Network

- **Strategy:** Magellan analyzes and reports geographic information on the Iowa Plan provider network.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Network Status Report
Reports delivered.
 - b) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.

Magellan Performance (August 2006 QI Annual Report): 100% for all quarters for all levels of need except for the October - December 2005 quarter when performance was 96% for emergency services and 98% for urgent.

c) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)

Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes;
Rural: Inpatient - 45 miles, Outpatient - 34 miles

Magellan Performance (August 2006 QI Annual Report): 100%

d) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments

Magellan Performance (August 2006 QI Annual Report): Evening - Mental Health 85%, Substance Abuse 98%; Weekend - Mental Health 55%, Substance Abuse 36%

- **Problems identified:** Lack of child psychiatry services in rural areas.
- **Corrective action** (plan/provider level): Continuation of Iowa Plan Community Reinvestment (Beneficiary Services) project with the University of Iowa Child Health Specialty Clinics to expand child mental health services capacity statewide through the use of telehealth resources and psychiatric staff.
- **Program change** (system-wide level):
Access to child mental health psychiatry services has been increased state-wide by making such resources available through the 14 regional Child Health Specialty Clinics. More than 1500 enrollee families are projected to benefit.

i. X

Measurement of any disparities by racial or ethnic groups

- **Strategy:** Magellan reviewed data to identify differences in utilization by Iowa Plan racial or ethnic groups.
- **Confirmation:** X Yes
- **Summary of results:** Magellan initiated a Performance Improvement Project in December 2005 entitled "Cultural Differences in Utilization.
- **Problems identified:** The Performance Improvement Project identified significant differences between the cultural make-up of the population of Iowa Plan members and the group of members utilizing Iowa Plan behavioral health services, particularly for Black/African American and Hispanic ethnicities.
- **Corrective action** (plan/provider level): Magellan initiated a Medicaid Community Reinvestment project to start culturally-specific (African American) outpatient substance abuse services in Des Moines.
- **Program change** (system-wide level): None

j. X

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

X Network Reports

- **Strategy:** Magellan submits documentation to the State that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.
- **Confirmation:** **X** Yes
- **Summary of results:**
 - a) Network Status Report
Information is submitted to the State in Network Status reports. Examples of provider types reviewed include psychiatrists, psychologists, social workers, and group practices.
Magellan Performance (August 2006 QI Annual Report): Reports submitted.
 - b) Penalty Performance Indicator #12: Network Management (Also QI Workplan: Timeliness of Credentialing and Re-Credentialing)
Goal: Credentialing of Iowa Plan providers shall be completed as follows: 60% in 30 days, 100% in 90 days.
Magellan Performance (August 2006 QI Annual Report): Two quarters were at 100%. One quarter was at 97.3% and one other was 95.2%.
 - c) Monitoring Performance Indicator #9: Compliance with Access Standards (Also QI Workplan: Accessibility of Behavioral Healthcare Services - Wait Times for Initial Appointments)
Goal: Enrollees with emergency needs are seen within 15 minutes of presentation/telephone contact; urgent non-emergency needs seen within 1 hour of presentation or 24 hours of telephone contact; persistent symptoms seen within 48 hours of reporting symptoms; routine services within four weeks of the request.
Magellan Performance (August 2006 QI Annual Report): 100% for all quarters for all levels of need except for the October - December 2005 quarter when performance was 96% for emergency services and 98% for urgent.
 - d) Monitoring Performance Indicator #10: Compliance with Geographical Standards of Access (Also QI Workplan: Network Adequacy - Access)
Goal: Urban: Inpatient - 30 minutes, Outpatient - 45 minutes; Rural: Inpatient - 45 miles, Outpatient - 34 miles
Magellan Performance (August 2006 QI Annual Report): 100%

- e) QI Workplan: Accessibility of Behavioral Healthcare Services - Availability of Evening and Weekend Appointments
Magellan Performance (August 2006 QI Annual Report):
Evening - Mental Health 85%, Substance Abuse 98%;
Weekend - Mental Health 55%, Substance Abuse 36%
- f) QI Workplan: Network Adequacy - Density
The number of providers per 1000 members.
Magellan Performance (August 2006 QI Annual Report):
6.87 providers per 1000 members
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X **Other - Credentialing**

- **Strategy:** Magellan's Professional Provider Review Committee (PPRC) is responsible for provider credentialing decisions for contracting under the Iowa Plan for Behavioral Health.
- **Confirmation:** **X** Yes
- **Summary of results:** PPRC reports were made to the QI Committee on a quarterly basis. For the July 2005-June 2006 Iowa Plan contract year, 681 providers were credentialed or re-credentialed by the Iowa PPRC. These included:
 - 404 Facilities/Agencies/Community Mental Health Centers
 - 111 Licensed Independent Social Workers
 - 37 Psychologists
 - 36 Psychiatrists
 - 4 Physician Assistants
 - 89 Other Masters Prepared Therapists (Advanced Registered Nurse Practitioners, Licensed Marriage and Family Therapists, Licensed Mental Health Clinicians, etc.)
- a) Penalty Performance Indicator #12: Network Management (Also QI Workplan: Timeliness of Credentialing and Re-Credentialing)
Goal: Credentialing of Iowa Plan providers shall be completed as follows: 60% in 30 days, 100% in 90 days.
Magellan Performance (August 2006 QI Annual Report):
Two quarters were at 100%. One quarter was at 97.3% and one other was 95.2%.
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X **Clinical On-site Review**

- **Strategy:** Clinical on-site review is conducted with providers to monitor the appropriateness and quality of clinical services delivered to members, compliance with Iowa Plan requirements, and associated documentation.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Incentive Performance Indicator #8: Quality of Care
Goal: $\geq 90\%$ of all discharge plans written for enrollees discharged from mental health inpatient shall be implemented; with ≥ 185 records reviewed.
Magellan Performance (August 2006 QI Annual Report): 96.2% of the 289 files reviewed
 - b) Penalty Performance Indicator #2: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from mental health inpatient, partial hospitalization, and day treatment.
Magellan Performance (August 2006 QI Annual Report): 99%
 - c) Penalty Performance Indicator #7: Quality of Care
Goal: A discharge plan shall be documented on the day of discharge for 90% of enrollees discharged from substance abuse residential treatment.
Magellan Performance (August 2006 QI Annual Report): 97.9%
 - d) QI Workplan: Clinical Practice Guidelines
Educate providers on Clinical Practice Guidelines and encourage compliance. Guidelines are posted on Magellan's website and may be distributed to providers directly or be reviewed during a Provider Roundtable.
Magellan Performance (August 2006 QI Annual Report): The following Clinical Practice Guidelines were in force during the 2005-2006 Iowa Plan contract year:
 - Assessing and Managing the Suicidal Patient
 - Assessment and Treatment of Patients with Eating Disorders
 - Assessment and Treatment of Patients with Post-Traumatic Stress Disorder and Acute Stress Disorder
 - Patients with Attention Deficit/ Hyperactivity Disorder
 - Treatment of Patients with Bi-Polar Disorder
 - Treatment of Patients with Major Depressive Disorder
 - Treatment of Patients with Panic Disorder
 - Treatment of Schizophrenia
 - Treatment of Substance Use Disorders
 - e) QI Workplan: Retrospective Treatment Record Reviews - Percent Compliance with Tool
Goal: 85%

Magellan Performance (August 2006 QI Annual Report):
88.3% Mental Health, 97% Substance Abuse

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

I. X

On-Site Review

X **External Quality Review**

- **Strategy:** DHS contracts with an External Quality Review Organization for annual review of Magellan and implementation of the Iowa Plan.
- **Confirmation:** X Yes
- **Summary of results:** The 2005-2006 EQR was conducted by the Iowa Foundation for Medical Care on behalf of the State on February 9, 2006. The objective of the evaluation was to measure the effectiveness of Magellan's Medicaid managed care program and processes in meeting the requirements of the Balanced Budget Act of 1997 as defined in the federal regulation (CFR 433 and 438). The content of the review included:
 1. Validation of Performance Improvement Projects (PIPs) that were underway during the preceding 12 months as required in 42 CFR 438.240 (b)(1).
 2. Validation of Performance Measures (PMs) that were underway during the preceding 12 months as required in 42 CFR 438.240 (b)(2). This included:
 3. A review to determine Magellan's compliance with the requirements of 42 CFR 438.240 (a)(1), specifically deficiencies and/or recommendations identified in the 2003/2004 EQR audit.
- **Problems identified:** Recommendations, which Magellan reviewed and identified as problems to be addressed, were:
 - Add second languages spoken to the emergency services section of the member Provider Directory.

- Maintain documentation in Critical Incident files that shows date, time and recipient for those incidents faxed to DHS.
- Continue improvement in documentation of Performance Improvement Projects and Performance Measures.
- Add a footnote to reports containing gender data stating the data are generated by the State.
- **Corrective action** (plan/provider level): Magellan implemented all EQR recommendations.
- **Program change** (system-wide level): None

m. X

Performance Improvement Projects [Required for MCO/PIHP]

X **Clinical**

- **Strategy:** Magellan implements at least two Performance Improvement Projects every year.
- **Confirmation:** X Yes
- **Summary of results:** Two Performance Improvement Projects (PIPs) have been initiated each Iowa Plan contract year since July 1, 2004:
 - a) The Intensive Care Management (ICM) PIP (July 2004) facilitates positive treatment outcomes through identification of high-need clients who could benefit from focused care management in order to achieve, consolidate and maintain treatment gains. It asks the study question: “Can ICM reduce 30 day re-admissions to mental health inpatient?”
 - b) The Outcomes Project PIP (October 2004) uses computer-based assessment tools to monitor client outcomes. It asks the study question: “Can the Outcomes Project improve clinical client outcomes?”
 - c) The Co-Occurring Disorders Services PIP (November 2005) piloted a model for integrated services for co-occurring mental health and substance symptoms. The PIP asks the study question: “Can co-occurring disorders services reduce the use of inpatient/residential behavioral health services?”
 - d) The Cultural Differences in Utilization PIP (December 2005) looks at Iowa Plan utilization data from the perspective of ethnicity and race as documented in Medicaid enrollment. It asks the study question: “Are there cultural differences in how Iowa Plan enrollees utilize behavioral health services?”
 - e) The Reward for Quality PIP (April 2006) provides financial incentives to providers for reducing hospital readmissions and emergency room presentations. It asks the study question: “Does support in the form of incentive payments

and technical assistance result in better program outcomes?”

- f) The Self-Directed Care PIP (May 2006) gives members participating in Intensive Psychiatric Rehabilitation (IPR) services the opportunity to fund specific goals through Recovery Purchasing Plans. It asks the study questions: “Does participation in the Self-Directed Care project result in improved recovery outcomes for IPR participants.”

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

n. X

Performance Measures [Required for MCO/PIHP]

Process

Health status/outcomes

Access/availability of care

Use of services/utilization

Health plan stability/financial/cost of care

Health plan/provider characteristics

Beneficiary characteristics

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

Problems identified:

- a) Incentive Performance Indicator #1: Readmission Rate (Also QI Workplan: 30-Day Readmission)

Goal: $\leq 15\%$

Magellan Performance (August 2006 QI Annual Report): 15.7%

- b) Monitoring Indicator #22: Quality of Care - Treatment of the Dually Diagnosed (Also QI Workplan: Dual Diagnosis Enrollee Follow-up)

Goal: 40% of dually diagnosed members discharged from inpatient substance abuse and mental health treatments receive both substance abuse and mental health services within seven working days of discharge.

Magellan Performance (August 2006 QI Annual Report): 9.8%

- **Corrective action** (plan/provider level): Three different Performance Improvement Projects were implemented that address readmission or services for co-occurring disorders.

- **Program change** (system-wide level): Findings from the Performance Improvement Projects will be implemented network-wide, as indicated.

p. X

Profile Utilization by Provider Caseload (looking for outliers)

X **Provider Profiling**

- **Strategy:** Magellan generates Provider Profiling each quarter for distribution to providers and analysis by Magellan and the State.
- **Confirmation:** X Yes
- **Summary of results:** Quarterly Provider Profiling was conducted with provider-specific and network aggregate reports delivered to providers.
- **Problems identified:** Certain providers had higher than average rates of non-authorizations and claim denials than other providers.
- **Corrective action** (plan/provider level): Provider-specific technical assistance was conducted.
- **Program change** (system-wide level): In general, providers reported that profiling helped them identify problem areas and most providers responded with internal changes.

X **Provider Medication Monitoring**

- **Strategy:** Magellan works with the Drug Utilization Review Commission to monitor provider prescribing practices.
- **Confirmation:** X Yes
- **Summary of results:** Magellan's Medical Director attends the State's Drug Utilization Review Commission (DUR) to assure coordination with the Iowa Plan and the fiscal agent that pays pharmacy.
 - a) Monitoring Performance Indicator #21: Psychotropic Medication

Goal: Magellan shall screen all client admitted to inpatient for psychotropic medication use. If the medication is not appropriate, intervention will be made with the prescribing doctor.

Magellan Performance (August 2006 QI Annual Report):
The percentage of clients using psychotropic medications at admission to inpatient ranged from 69.9% to 75.2% per month.
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

q. X

Provider Self-Report Data

X **Survey of Providers**

- **Strategy:** Magellan administers a provider satisfaction survey each year.
- **Confirmation:** X Yes
- **Summary of results:**
 - a) Monitoring Performance Indicator #16: Provider Satisfaction Survey (Also QI Workplan: Provider Satisfaction)
 Goal: Magellan will conduct an annual provider survey in which $\geq 75\%$ of network providers responding indicate satisfaction.
 Magellan Performance (August 2006 QI Annual Report): 84.4%
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

X **Focus Groups**

- **Strategy:** Magellan conducts quarterly Provider Roundtables and providers are included in the Iowa Plan Advisory Committee and the Clinical Advisory Committee.
- **Confirmation:** X Yes
- **Summary of results:** Regularly scheduled Iowa Plan Provider Roundtables and advisory committee meetings were held. In addition, Magellan management staff attended regular meetings of Community Mental Health Centers, county Central Point of Coordination and DHS staff, and statewide substance abuse organizations.
 Magellan conducted two trainings for Iowa Plan providers during the 2005-06 contract year. Both trainings were done over Iowa's interactive fiber-optic network (ICN) as part of Iowa Plan Provider Roundtables:
 - "Childhood Depression"
 - "Clinical Practice Guideline for the Treatment of Adults with Substance Abuse Disorders "
- **Problems identified:** None
- **Corrective action** (plan/provider level): None
- **Program change** (system-wide level): None

s. X

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

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

policies. Annual review of the UMGs was conducted with the Clinical Advisory Committee. Current UMGs are made available to all providers and are available to members and families upon request. Utilization review is monitored through Performance Indicators and the QI Workplan.

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

- a) Incentive Performance Indicator #4: Involuntary Hospitalization
Goal: The percent of involuntary admission to mental health inpatient shall not exceed 15% for children and 10% for adults.
Magellan Performance (August 2006 QI Annual Report): 4.1%
- b) Incentive Performance Indicator #5: Service Array
Goal: At least 6% of mental health service expenditures will be used in the provision of integrated services and supports.
Magellan Performance (August 2006 QI Annual Report): 6.5%
- c) Incentive Performance Indicator #6: Quality of Care (Also QI Workplan: 7-Day Ambulatory Follow-up)
Goal: $\geq 90\%$ of persons discharged from mental health inpatient will receive other treatment services in seven days.
Magellan Performance (August 2006 QI Annual Report): 90.5%
- d) Incentive Performance Indicator #7: Quality of Care
Goal: $>60\%$ of enrollees discharged from ASAM Levels III.5 and III.3 receive a follow-up substance abuse service in 14 days.
Magellan Performance (August 2006 QI Annual Report): 69.1%
- e) Penalty Performance Indicator #4: Quality of Care
Goal: $\geq 95\%$ of enrollees who received services in an emergency room and for whom inpatient was requested but not authorized shall have a follow-up contact in three business days of the date Magellan is notified of the ER service.
Magellan Performance (August 2006 QI Annual Report): Ranged from 95.6% to 99.2%
- f) Monitoring Performance Indicator #18: Dual Diagnosis
Goal: Magellan will identify dually diagnosed clients admitted to inpatient or residential and track the follow-up services received.
Magellan Performance (August 2006 QI Annual Report): Ranged from 15.4% to 47.4% of clients admitted to mental health inpatient received mental health and substance abuse follow-up services. Ranged from 27.6% to 58.1% of clients admitted to substance abuse inpatient who received mental health and substance abuse follow-up services.
- g) Monitoring Indicator #19: Emergency Room
Goal: Magellan will monitor the number and percentage of clients presenting to the emergency room who had a service 30 days prior.
Magellan Performance (August 2006 QI Annual Report): 38.5% to 47%
- h) QI Workplan: Clinical Non-authorizations per 1,000

Magellan Performance (August 2006 QI Annual Report): 5.45
clinical non-authorizations per 1000 members

i) QI Workplan: Clinical Authorizations per 1,000

Magellan Performance (August 2006 QI Annual Report): 169.45
clinical authorizations per 1000 members

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

Section D – Cost-Effectiveness – Waiver Period SFY 08 – SFY 09

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:
Rick Swizdor
- c. Telephone Number: **515-281- 0189**
- d. E-mail: **rswizdo@dhs.state.ia.us**
- e. The State is choosing to report waiver expenditures based on **X** date of payment.
 ___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.
Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.

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

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

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

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

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

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

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

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

For Conversion or Renewal Waivers:

- a. [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: **Member months were projected based on historical state experience in the base years by MEG. Also, MEG 3 projected member months were increased by 1.1% to reflect the expected increase in foster care eligibility.**
- d. [Required] Explain any other variance in eligible member months from BY/R1 to P2: **Eligible member month differences between the**

prospective and retrospective years are due to an expected increase in enrollment. Also considered was the increase in foster care eligibility.

- e. [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **R1 = SFY06 R2 = SFY07 Qtr 1. Since R2 is a quarterly number and P1 is annual, cell I15 on the D1. Member Months tab was annualized.**

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

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

For the capitated services, the benefit changes (new B(3) services, expansion of diagnostic services, additional LPHA costs, additional costs for older foster care children, and legislated payment increases) have been accounted for in the capitation rate. For the FFS services, an adjustment has been made to account for the adult and children rehab services change to remedial services following a more clinical model.

The significant increases in costs/utilization between SFY 2005 and SFY 2006 were primarily due to Prescription Drugs. This large increase does not appear reasonable. According to the "Drug Rebates as a Percentage of Drug Expenditures" report, the waiver's Prescription Drug expenditures went from \$15.3 million in SFY 2005 to \$78.2 million in SFY 2006. This correlates to the Iowa Waiver having approximately 4.1% of total drug expenditures in SFY 2005 and approximately 30.5% of total drug expenditures in SFY 2006. Total drug expenditures (calculated as the sum of the Form 64.9, Form 64.9 Waiver, Form 64.21 U, and Form 64.21 U Waiver) actually decreased over 17% during this time. The decrease reflects the impact of Medicare Part D changes.

For SFY 2006 Q4, the State reported no MEG 1 FMAP capitations paid. Instead, they reported \$8.46 million in Medicare Part B payments. In SFY 2007 Q1, the State reported a negative \$8.46 million in Medicare Part B payments and reported approximately twice the expected capitation payments (\$16.66 million). Since only "Prepaid Inpatient Health Plan" amounts were considered Capitations Paid, Medicare Part B payments were considered a FFS wraparound

payment in SFY 2006 Q4. This resulted in a large increase in capitations paid between SFY 2006 Q4 and SFY 2007 Q1. It also resulted in a large decrease in wraparound payments between SFY 2006 Q4 and SFY 2007 Q1. In fact, the adjustment has resulted in a negative wraparound payment for SFY 2007 Q1.

Administrative costs have also been higher than expected.

The incentive payment made in R1 was not included on Schedule D. It has been added to column D of D3. Actual Waiver Cost.

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: none

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

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

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	\$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. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. X The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs. Through a discussion between CMS and the State, it has been decided that the State may continue to allocate all administrative costs to MEG 1.*
- c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

In completing this assignment, Milliman has relied on data provided by the State of Iowa, its fiscal agent, and Magellan Behavioral Care of Iowa. We have reviewed this data for reasonableness but have not audited it. During this review, it was determined that an unreasonable increase in costs occurred between SFY 2005 and SFY 2006. These increases were not anticipated in the prior waiver submission. The State has requested that Section D of the waiver be completed with the available data as the State continues to determine the reasons for the increase.

The significant increases in costs/utilization between SFY 2005 and SFY 2006 were primarily due to Prescription Drugs. This large increase does not appear reasonable. According to the “Drug Rebates as a Percentage of Drug Expenditures” report, the waiver’s Prescription Drug expenditures went from \$15.3 million in SFY 2005 to \$78.2 million in SFY 2006. This correlates to the Iowa Waiver having approximately 4.1% of total drug expenditures in SFY 2005 and approximately 30.5% of total drug expenditures in SFY 2006. Total drug expenditures (calculated as the sum of the Form 64.9, Form 64.9 Waiver, Form 64.21 U, and Form 64.21 U Waiver) actually decreased over 17% during this time. The decrease reflects the impact of Medicare Part D changes.

For SFY 2006 Q4, the State reported no MEG 1 FMAP capitations paid. Instead, they reported \$8.46 million in Medicare Part B payments. In SFY 2007 Q1, the State reported a negative \$8.46 million in Medicare Part B payments and reported approximately twice the expected capitation payments (\$16.66 million). Since only “Prepaid Inpatient Health Plan” amounts were considered Capitations Paid, Medicare Part B payments were considered a FFS wraparound payment in SFY 2006 Q4. This resulted in a large increase in capitations paid between SFY 2006 Q4 and SFY 2007 Q1. It also resulted in a large decrease in wraparound payments between SFY 2006 Q4 and SFY 2007 Q1. In fact, the adjustment has resulted in a negative wraparound payment for SFY 2007 Q1.

If the base year data is flawed, our estimates will need to be revised. If the data provided to us for use in the prior waiver was flawed, our estimates for the prior waiver would need to be revised.

Schedule D was used to determine the base year period costs. Schedule D provided a total payment amount for SFY 2006 and SFY 2007 Q1 by MEG. Schedule F provided additional information on the

amounts of capitations, wraparounds, and administrative costs paid in the base years. The split of capitations paid between state plan services and B(3) services was based on the split contained in the actuarial report for the corresponding rating period. Base period member months were provided to us on the Eligible Member Months Report.

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

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

Beneficiary Services: Up to 70% of the Community Reinvestment fund shall be used for direct services to enrollees. These shall be additional 1915(b)(3) services to enrollees as allowed under the cost savings aspect of the waiver. All such projects shall meet the prior approval of the Department and CMS. The Department, at its sole discretion, may determine that funds in this category be used to increase provider payments so as to achieve enhanced access or maintain access as appropriate to meet the needs of the enrollees. Funds remaining in the enrollee services category shall continue to be held in the account to be used for direct services. Such funds that remain unspent or otherwise unencumbered and will be returned to the Department at the termination of the contract.

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

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

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

The contractor may not share in any portion of Community Reinvestment funding for the purpose of payment of administration or overhead of the program or as a profit.

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		(PMPM in Appendix D5 Column W x projected member months should correspond)

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation Projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital</i>	<i>\$1,751,500 or \$.97 PMPM R1 \$1,959,150 or \$1.04 PMPM R2 or BY</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1 \$2,291,216 or 1.10 PMPM in P2</i>

<i>care. See attached documentation for justification of savings.)</i>	<i>in Conversion</i>		
B(3) services were not tracked separately in the base year. Please see below a description of how the numbers were estimated.	\$27,017,682 or \$8.03 PMPM R1 \$6,671,730 or \$7.94 PMPM R2	-4.4% annual or \$-1,167,502 from R2 to P1 (R2 only has 1 quarter of data and is 16.5 months from P1) 6.4% annual or \$1,626,466 from P1 to P2	\$25,519,417 or \$7.37 PMPM P1 and \$27,145,884 or \$7.67 PMPM 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)

The State does not track B(3) and State Plan capitations separately. The B(3) and State Plan capitation rates provided in the actuarial reports were used to split the capitations paid in the base year for cost-effectiveness purposes. The SFY 2005 and SFY 2006 actuarial reports were used for this split as the SFY 2006 rates were not effective until January 1, 2006. The capitation rates were developed using encounter data.

- 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. The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to ~~purchase reinsurance coverage privately~~ provide for insolvency issues. No adjustment was necessary.

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

In addition to the significant positive equity, MBCI is required, as a contract condition, to maintain an insolvency account with a balance of \$12 million. This is a custodial account that the state has access to should MBCI default. The amount in the account covers the outstanding debt at any given time.

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

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

1. [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and

- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

In March 2006, an incentive payment of \$875,000 was paid to the contractor. Per the State, the incentive payment was not included on Schedule D. No incentives were paid in SFY 2007 Qtr 1. The incentive was added to the Schedule D amount on D3 . Actual Waiver Cost for R1. The \$875,000 was allocated to the MEGs based on capitations paid (State Plan + B(3)) and then added to the State Plan amount in column D.

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

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP – Not Applicable See Section J

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some

states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
2. ___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ___ State historical cost increases. Please indicate the years on which the rates are based: base years_____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.
 - i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ___ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral

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

Others:

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

- C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - iv. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - v. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):
- c. ___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.
- 1. ___ No adjustment was necessary and no change is anticipated.
 - 2. ___ An administrative adjustment was made.
 - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
 - ii. ___ FFS cost increases were accounted for.

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

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2. ___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e.,*

trending from present into the future), the State must use the State's trend for State Plan Services.

- i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

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

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

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

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

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

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

Method:

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9

Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. ___ The State had no recoupments/payments outside of the MMIS.

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

Basis and Method:

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

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

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

Method:

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

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

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

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

Basis and Method:

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

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

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

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

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

Special Note section:

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

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

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

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

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to

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

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

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

Documentation of assumptions and estimates is required for this adjustment.

1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. ___ Other (please describe):

- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
 - 1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 - 2. ___ This adjustment was made in the following manner:

- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
 - Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 - 1. ___ No adjustment was made.
 - 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner.

CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
 1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: **8.31% for all MEGs for R2 to P1 and 2.31% for all MEGs for P1 to P2.** Please document how that trend was calculated:

Please note that the above percentages are not entirely trend but also include the effect of rebasing. Prior to January 1, 2006, the rates were based on 1995 fee-for-service data. The SFY 2006 (implemented January 1, 2006) capitation rates were developed using SFY 2004 encounter data. The rates to be implemented in SFY 2007 are based on SFY 2006 encounter data. There were significant shifts by rate cell. The cost effectiveness demonstration reflects these shifts in costs.

The trend used in the SFY 2007 (October 2006 – June 2007) capitation rate methodology was limited to the State Plan trend. The trend was based on linear regression of the monthly encounter data for SFY 2005 and 2006. This resulted in a historical annual utilization trend rate of 1.1%. Only State Plan services were used in this calculation. The trend rate for B(3) services was held to the same rate as for State Plan services because the calculated rate would have been higher. Based on information provided by the State, an additional 3% was added to the trend factor to account for legislated price increases.

Trends for the wraparound services were based on the historical experience of the FFS costs reported on the ACS MEG reports for the period SFY 2003-SFY 2005. SFY 2006 was not used because of the significant increase in prescription drug costs.

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

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

- i. X State historical cost increases. Please indicate the years on which the rates are based: base years R1=SFY 2006; R2 = SFY 2007 Qtr 1 . In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. (**see above**)
- ii. National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used . In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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

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

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

Others:

- Additional State Plan Services (+)

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

The costs for Medicare Part D covered drugs and well as their associated rebate impact have been taken out of the base year data.

- E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
 - iv. ___ Changes brought about by legal action (please describe): For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

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

Pharmacy Rebate Factor - An adjustment was made to account for drug rebates not excluded from the base year. Prescription drug rebate information was not available specifically for the Iowa Plan. As requested by CMS, the ratio of IA Plan Prescription Drug costs to Total Prescription Drug Expenditures for the entire program was used to estimate the percentage of Drug Rebates that would have been expected in the Iowa Plan. Rebates for Title XIX were assumed to be 28.18% while Title XXI rebates were assumed to be 29.91%.

Incentive Factor – No incentive payment was made in SFY 2007 Qtr 1. An adjustment factor was added to account for the expected incentive to be paid in P1 and P2.

Remedial Treatment Services – A program change has been made to reflect an expected \$91,304,128 for ARO/RTSS/Habilitation costs in P1. These costs are replacing the costs for the current ARO and RTSS services.

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. X An administrative adjustment was made.
 - i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - ii. X Cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. X State Historical State Administrative Inflation. The actual trend rate used is: 16.70% for R2 to P1 and 10.41% for P1 to P2. Please document how that trend was calculated:

The rate of inflation was based on linear regression on the historical administrative cost experience as well as actuarial judgment. There were significant administrative costs over the past few years (i.e., IME implementation costs) that would not continue to impact trend. These were reduced prior to the linear regression.

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: **-7.23% for all MEGs from R2 to P1 and 4.10% for all MEGS from P1 to P2**. Please provide documentation

Please note that the above percentages are not entirely trend but also include the effect of rebasing. Prior to January 1, 2006, the rates were based on 1995 fee-for-service data. The SFY 2006 (implemented January 1, 2006) capitation rates were developed using SFY 2004 encounter data. The rates to be implemented in SFY 2007 are based on SFY 2006 encounter data. There were significant shifts by rate cell. The cost effectiveness demonstration reflects these shifts in costs.

The trend used in the SFY 2007 (October 2006 – June 2007) capitation rate methodology was limited to the State Plan trend. The trend was based on linear regression of the monthly encounter data for SFY 2005 and 2006. This resulted in a historical annual utilization trend rate of 1.1%. Only State Plan services were used in this calculation. The trend rate for B(3) services was held to the same rate as for State Plan services because the calculated rate would have been higher. Based on information provided by the State, an additional 3% was added to the trend factor to account for legislated price increases.

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 **R1=SFY 2006; R2 = SFY 2007 Qtr 1**
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

(see above) An annual trend of 4.1% (cost and utilization) was used in the development of the capitation rate for B(3) services in the most recent rate setting. This is based on the increase for non-B(3) services.

- 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):

The costs and the associated rebates of Dual Eligible Medicare covered drugs have not been included in the base year costs.

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

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

Member months were projected based on historical state experience in the base years by MEG. Also considered was the increase in foster care eligibility.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

The cost effectiveness demonstration includes the change from the base year rates to the anticipated P1 and P2 rates. The trends for capitated services were based on utilization and cost trends in addition to the rates developed in the most recent rate setting. Trends for the wraparound services were based on the historical experience of the FFS costs reported on the ACS MEG reports.

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**:

Please note that the above percentages are not entirely trend but also include the effect of rebasing. Prior to January 1, 2006, the rates were based on 1995 fee-for-service data. The SFY 2006 (implemented January 1, 2006) capitation rates were developed using SFY 2004 encounter data. The rates to be implemented in SFY 2007 are based on SFY 2006 encounter data. There were significant shifts by rate cell. The cost effectiveness demonstration reflects these shifts in costs.

The trend used in the SFY 2007 (October 2006 – June 2007) capitation rate methodology was limited to the State Plan trend. The trend was based on linear regression of the monthly encounter data for SFY 2005 and 2006. This resulted in a historical annual utilization trend rate of 1.1%. Only State Plan services were used in this calculation. The trend rate for B(3) services was held to the same rate as for State Plan services because the calculated rate would have been higher. Based on information provided by the State, an additional 3% was added to the trend factor to account for legislated price increases.

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

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.



AppendixDrenewal12
0104(1)022207.xls