



## Iowa Department of Public Health Advancing Health Through the Generations

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Thomas J. Vilsack  
Governor

Sally J. Pederson  
Lt. Governor

Mary Mincer Hansen, R.N.,PhD.  
Director

Thank you for the opportunity to testify before you this afternoon. I am Janet Zwick, Deputy Director, for the Iowa Department of Public Health, and Director for the Division of Behavioral Health and Professional Licensure. Substance abuse prevention and treatment programs are located in this division.

I am addressing substance abuse program financing today. Iowa began managed care in 1995. The first contract was the Iowa Managed Substance Abuse Care Plan (IMSACP). It included Medicaid, Department of Public Health state funding, and the Substance Abuse and Mental Health Administration (SAMHSA) block grant.

The current plan is called the Iowa Plan for Behavioral Health and incorporates both mental health and substance abuse services. The Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (DPH) are the State authorities that oversee the Iowa Plan. Magellan Behavioral Care of Iowa has the management contract.

There are three distinct funding streams in the Iowa Plan, each with specific policies and procedures:

- DPH funding for substance abuse services is a set annual amount from the federal block grant and state appropriations. Funding remains constant, regardless of the number of clients who present for services.
- Medicaid funding for mental health and substance abuse services is based on enrollment. Higher enrollment means more funding for services.

- State Payment Program funding for mental health services is based on the actual services authorized and paid.

Magellan is paid a set percentage of Medicaid funding for administrative costs and is at-risk for Medicaid service dollars. Magellan acts as an Administrative Service Organization and is paid administrative fees for activities related to DPH-funded substance abuse services and State Payment Program mental health services.

Three types of clients, consistent with the funding streams, are eligible for Iowa Plan services:

- Medicaid Enrollees - Enrollment, determined by DHS, is mandatory and automatic for most Medicaid beneficiaries.
- DPH-Funded Participants - Providers determine client eligibility for DPH-funded substance abuse services based on criteria.
- State Payment Program Members (SPP)- DHS enrolls SPP members who:
  - have no county of legal settlement and,
  - are designated as having a mental illness or chronic mental illness.

The Iowa Plan covers a full range of mental health and substance abuse services. Since this hearing is directed towards substance abuse, the remainder of my testimony will focus on substance abuse services.

Substance abuse services range from detoxification and inpatient (Medicaid only), assessment, outpatient services, halfway house, and residential treatment. Magellan manages the intensive Medicaid services. Substance abuse treatment providers manage DPH-funded services and do not require

authorization. Magellan monitors these services through retrospective on-site clinical review. All care decisions are guided by the American Society of Addiction Medicine (ASAM) criteria.

The Medicaid substance abuse provider network is an open panel. Qualified providers contract with Magellan to serve Iowa Plan clients. All substance abuse treatment providers must be licensed by DPH. DPH-funded providers are selected for contracting with Magellan through a competitive Request for Proposals process.

Each funding stream has its own payment system.

- For Medicaid substance abuse services, providers submit claims to Magellan. Medicaid enrollees cannot be billed for Iowa Plan services.
- For DPH-funded substance abuse services, providers contract with Magellan for a total amount of funding for the year. Magellan pays each provider 1/12<sup>th</sup> of their annual funding each month. DPH-funded clients may be billed a co-pay by the provider based on a sliding fee scale that considers income and family size.

There are extensive regulatory and quality improvement requirements in the Iowa Plan. Initially DHS and DPH met with Magellan on a weekly basis, but that has been reduced to once a month for policy level review and twice a month for on-going coordination of operational issues. All three parties participate in a monthly Quality Improvement Committee that includes consumer, family and provider representatives.

Opportunities for provider input include 3 advisory committees and other roundtables.

Magellan's management of the Iowa Plan is evaluated quarterly against 49 performance indicators, developed by DHS and DPH with stakeholder input.

- 13 Medicaid indicators carry financial penalties; examples:
  - Follow-up on emergency room visits (90% in 3 days)
  - Time frames for claims payment (85% in 12 calendar days)
- 8 Medicaid indicators carry financial incentives; examples:
  - Reducing hospital readmission rates ( $\leq 15\%$  at 30 days)
  - Follow-up of discharge from the hospital within 7 days (90% of discharges)
- 6 DPH indicators carry liquidated damages; examples:
  - Number of clients served (19,154 for contract year)
  - Service mix (27.5% women, 12.5% race other than white, etc)
  - Compliance with block grant regulations (IV drug user and pregnant women access)
- 22 Medicaid monitoring indicators; examples:
  - Access standards (geographic, time-based, and penetration rates)
  - Intensive care management for clients with complex symptoms
  - Services to clients with dual mental health and substance abuse diagnoses

The Iowa Plan is regularly evaluated by external entities including the Centers for Medicare and Medicaid Services, the Iowa Insurance Division, the Substance Abuse and Mental Health Services Administration, and the Utilization Review Accreditation Commission accreditation organization. A Medicaid External Quality Review is conducted annually by William H. Mercer, Inc. In its August 2000 Independent Assessment report to DHS, William H. Mercer, Inc. stated:

*Mercer's overall conclusion is that the Iowa Plan clearly meets Center for Medicaid Services guidelines and requirements in terms of access, quality, and cost effectiveness. Further, based on our extensive knowledge and experience with similar programs in other states, we consider the Iowa*

*Plan to be exemplary in most major areas of concern, and can be considered a national leader and model program.*

Accomplishments:

- Client satisfaction survey results averaged 90% in 2004 to 2005.
- Provider satisfaction for 2004 to 2005 was 86%.
- Substance abuse Medicaid providers increased from 26 to 63.
- Access to substance abuse treatment increased by 187% over the prior fee-for-service system.
- The number of specialized substance abuse treatment programs serving women with children expanded from 3 programs to 10.
- Medicaid coverage expanded beyond hospital-based treatment to include community-based residential and outpatient services.
- Data service reporting required of all Iowa Plan substance abuse providers.
- The budget for substance abuse Medicaid services was increased from approximately \$2 million in 1995 to \$13.5 million in 2005.

A unique benefit of the Iowa Plan has been the establishment of Medicaid Community Reinvestment and DPH incentive funding.

- DPH incentive funding is used solely as additional reimbursement to those providers who provide services above their contractual requirement.
- Medicaid Community Reinvestment funding is for enhancement or expansion of behavioral health services. The fund is comprised of 2.5% of the Medicaid capitation as well as any unspent Medicaid service dollars. Examples of Medicaid Community Reinvestment projects specific to substance abuse include:
  - ASAM and Motivational Interviewing training for all substance abuse providers,
  - Integrated services for co-occurring disorders

This funding arrangement has significantly improved services to substance abuse clients. Thank you for this opportunity. I will be glad to answer any questions you may have.

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5 Key Recommendations from the oral testimony:

- 1) Medicaid and substance abuse block grants complement each other.
- 2) Need to secure the infrastructure for substance abuse prevention and treatment.
- 3) Need to turn research into practice.
- 4) Regardless of where the SSA sits, look at: visibility of director, knowledge, collaboration, law enforcement, treatment and prevention providers.
- 5) Having some sort of policy advisory council reporting to the governor that has all agencies involved.