



Iowa Plan for Behavioral Health

Provider Handbook Supplement



Call (800) 638-8820 or (515) 223-0306
www.MagellanofIowa.com



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1. Iowa Plan Supplement Introduction

Welcome to the Magellan Behavioral Care of Iowa (Magellan) Provider Handbook Supplement for the Iowa Plan for Behavioral Health. This handbook supplements the Magellan National Provider Handbook, addressing policies and procedures specific for the Iowa Plan for Behavioral Health. The supplement for Iowa Plan for Behavioral Health is to be used in conjunction with the national handbook. When information in the Iowa Plan for Behavioral Health Supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in the Iowa Plan for Behavioral Health Supplement prevail.

The Iowa Plan Provider Handbook Supplement and the Magellan National Provider Handbook is available on our website at www.magellanofowa.com or by contacting Magellan at 1-800-638-8820.

Changes to Iowa Plan policies, procedures, or requirements are communicated to providers at least 30 days prior to the effective date of the change through specific provider communications. If the planned change confers a benefit on the provider, the 30-day notice period will not be required.

Iowa Plan for Behavioral Health Overview

The Iowa Plan vision, as articulated by the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) in the Iowa Plan for Behavioral Health Requests for Proposals is as follows:

The Iowa Plan for Behavioral Health is part of a statewide recovery-oriented care system that supports Eligible Persons and their families in their personal recovery efforts related to mental health and substance abuse disorders. The Iowa Plan promotes a broad infrastructure of services and supports statewide and coordinates with other related service delivery systems and recovery supports.

2. Eligibility

Eligibility – Iowa Plan Medicaid

It is the provider's responsibility to verify Medicaid eligibility and Iowa Plan enrollment each month a service is rendered.

If the client's mental or physical condition at admission does not allow the client to communicate with the provider about health care coverage, the provider should document that in the clinical record. Client language barriers that prohibit communication also should be documented. (Such documentation is considered during the appeals process.)

Enrolled Individuals

Enrollment in the Iowa Plan is mandatory and automatic for Medicaid beneficiaries, except for those in categories which are specifically excluded. (Excluded beneficiaries are noted below.) Medicaid eligibility is determined by the Department of Human Services (DHS) on a monthly basis. Magellan will assist in the transition of clients whose Medicaid eligibility changes, as requested.

The Iowa Plan serves two types of clients:

- Medicaid enrollees supported by Medicaid funding administered by DHS
- IDPH-funded participants supported by federal block grant and state appropriation administered by the Iowa Department of Public Health (IDPH).

While the words "Enrollees" and "Participants" refer to individuals whose services are supported by a specific funding stream and are used when referencing a particular funding stream, the word "client" is used throughout the Provider Supplement to refer in general to individuals receiving Iowa Plan mental health or substance abuse services. The following Medicaid beneficiaries are not enrolled in the Iowa Plan:

- persons who are eligible for Medicaid as a result of spending down excess income (medically needy with a cash spend-down),
- persons enrolled in the PACE program,
- persons living in the Woodward State Hospital-School or the Glenwood State Hospital-School, and
- persons whose Medicaid benefit package is limited, i.e., Qualified Medicare Beneficiaries (QMB), persons who are presumptively Medicaid eligible, illegal aliens, and others not entitled to the full range of mental health and substance abuse treatment included in the Iowa Medicaid fee-for-service program.
- Iowa Plan Enrollees not Eligible for Iowa Plan Services

A person who is an inmate of a non-medical public institution such as a jail or other public penal institution is not eligible for Medical Assistance and thus is not eligible for services through the Iowa Plan. If a person enters such an institution in the middle of a month for which Medicaid eligibility was already granted prior to the person entering the institution, any medical services received in the portion of that month while he or she was an inmate are not Medicaid payable (even though the person has a valid Medicaid card for that month).

Month of Application

Month of application (MOA) clients are those individuals who are not eligible for Medicaid at the time they receive Iowa Plan services, but who have applied for or intend to apply for Medicaid benefits. Such individuals may or may not gain Medicaid eligibility and may or may not gain Iowa Plan enrollment.

If Medicaid eligibility is gained, the client may be enrolled in the Iowa Plan. Enrollment is retroactive only to the month in which application was made, even if Medicaid eligibility is gained for months previous to the month of application. There are two exceptions to this: Iowa Plan enrollment is retroactive to the month of admission for 1) children admitted to the child/adolescent treatment units at the Cherokee or Independence Mental Health Institutes and 2) children admitted to Psychiatric Medical Institutions for Children. Eligibility for both these exceptions is further described in the paragraphs that follow.

While the decision to treat rests with the provider, it is recommended that providers authorize services to potential MOA clients as if they are Iowa Plan enrolled in order to ensure payment for the services if the client becomes Medicaid eligible.

Retroactive enrollment for children in PMICs and MHI child/adolescent treatment programs

Children admitted to a PMIC or to a child/adolescent treatment unit at Cherokee Mental Health Institute or Independence Mental Health Institute, often apply for and gain Medicaid eligibility in aid type 377 due to their out-of-home placement, upon or after admission. Magellan manages all admissions to these settings as if that person had been a Medicaid enrollee at the date of admission.

If a child is admitted to a substance abuse licensed PMIC or to a child/adolescent treatment unit at Cherokee Mental Health Institute or Independence Mental Health Institute, and is a Medicaid member or later becomes a Medicaid member (including gaining retroactive Medicaid eligibility which typically includes up to three months of eligibility prior to application) for all or any of the months that the person resides in the PMIC, the child will be considered an Iowa Plan enrollee regardless of whether the child is designated an enrollee (by inclusion on the Contractor's enrollment data). The Contractor will work with the PMICs to ensure that all Medicaid Members have Iowa Plan eligibility from the month of entry to the substance abuse PMIC.

Mental Health Institutes - Adults

Iowa Plan policies and procedures apply for adults over 21 years of age admitted to a state Mental Health Institute (MHI) on a voluntary basis. For mental health services, this includes the Cherokee, Clarinda and Independence state mental health hospitals. For substance abuse services, this includes inpatient care at the licensed substance abuse treatment program at the Mount Pleasant Mental Health Institute. Adults admitted to an MHI under court order for treatment services are not covered under the Iowa Plan. Court ordered mental health evaluations are authorized for up to five days.

Eligibility – Iowa Plan IDPH-Funded Substance Abuse

Providers contracted to provide IDPH-funded services determine client eligibility for such services at the time the client requests services. Eligibility applies for individuals meeting the following conditions:

- resident of the State of Iowa, and
- income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services, and
- third party payment is not available to pay for covered services.

Women and Children Services

Pregnant women and women with children, including those who have custody of their children as well as those seeking custody, are eligible for enhanced substance abuse treatment and ancillary supportive services through Women and Children Programs.

To be eligible for IDPH-funded Women and Children Program treatment and ancillary services, the woman must meet IDPH-funding eligibility requirements. Women who are enrolled in the Iowa Plan through Medicaid may receive treatment under Medicaid and ancillary services through IDPH funding.

Individuals Not Eligible for IDPH-Funded Substance Abuse Services

The following individuals are not eligible for IDPH-funded services:

- Medicaid beneficiaries enrolled in the Iowa Plan, including those persons who have applied for or intend to apply for Medicaid, and who become Medicaid enrollees in the Iowa Plan
- An inmate of a non-medical public institution such as a public jail or other type of public penal institute.

3. Covered Benefits

Covered Diagnoses – Iowa Plan Medicaid

Diagnostic series covered for Iowa Plan Medicaid enrollees, as defined in the ICD-9-CM, are listed below. Substance abuse diagnoses are indicated in italics.

290	Senile and presenile organic psychotic conditions
291	Alcoholic psychoses
292	Drug psychoses
293	Transient organic psychotic conditions
294	Other organic psychotic conditions (chronic)
295	Schizophrenic disorders
296	Affective psychoses
297	Paranoid states
298	Other non-organic psychoses
299	Psychoses with origin specific to childhood
300	Anxiety disorders
301	Personality disorders
302	Sexual deviations and disorders
303	<i>Alcohol dependence syndrome</i>
304	<i>Drug dependence</i>
305	<i>Non-dependent use of drugs</i>
306	Physiological malfunction arising from mental factors
307	Special symptoms or syndromes, not elsewhere classified
308	Acute reaction to stress
309	Adjustment reaction
311	Depressive disorder not elsewhere classified
312	Disturbance of conduct, not elsewhere classified
313	Disturbance of emotions specific to childhood and adolescence
314	Attention deficit disorder

The following ICD-9 diagnosis series are excluded unless the enrollee also has a diagnosis which is covered under the Iowa Plan:

315	Specific delays in development
316	Psychic factors associated with diseases classified elsewhere
317	Mild mental retardation
318	Other specific mental retardation
319	Unspecified mental retardation

Covered Diagnoses – Iowa Plan IDPH-Funded Substance Abuse

Covered diagnoses for Iowa Plan IDPH-funded participants include the following:

- Non-Dependent Abuse of Alcohol
- Alcohol Dependency
- Drug Dependency
- Non-Dependent Abuse of Drugs

- Intervention for Significant Others when there is no identified diagnosed substance abuse client

Covered Services - Iowa Plan Medicaid Mental Health

- Ambulance services for psychiatric conditions which includes both emergent and non-emergent situations
- Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year
- Inpatient hospital care for psychiatric conditions
- Subacute services in a 24-hour treatment facility
- 23-hour observation in a 24-hour treatment facility
- Dual diagnosis mental health and substance abuse treatment provided at the state mental health institute at Mount Pleasant
- Outpatient hospital care for psychiatric conditions including:
 - intensive outpatient services
 - individual and group therapy
 - occupational therapy
 - medication administration
 - activity therapies
 - family counseling
 - partial hospitalization
 - day treatment
- Psychiatric physician and certified psychiatric advanced registered nurse practitioner services, including consultations requested for enrollees receiving treatment for other medical conditions
- Services of a licensed psychologist for testing/evaluating and treatment of mental illness
- Services in state mental health institutes for enrollees under the age of 21 through the age of 22 if the enrollee is hospitalized on the enrollee's 21st birthday
- Services in state mental health institutes for enrollees 65 and over
- Services provided through a community mental health center including:
 - services of a psychiatrist
 - services of a clinical psychologist
 - services of a licensed social worker
 - services of a psychiatric nurse
 - day treatment
- Home Health Agency
- Targeted case management services to persons with chronic mental illness
- Medication management

- Medication Compliance Management
- Psychiatric nursing services by a home health agency
- Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes
- Mental health services determined necessary subsequent to an EPSDT program screening
- Second opinion as psychosocially necessary and appropriate for the enrollee's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the enrollee
- Physical examinations performed for a patient being admitted for mental health reasons to an inpatient setting, providing such inpatient admission was authorized according to Iowa Plan policies
- Office visits to non-psychiatric physicians for mental health reasons in excess of 12 office visits per enrollee per state fiscal year
- With the exception of those services provided in an inpatient setting, the cost of prescription drugs and laboratory testing for Medicaid enrollees receiving mental health services is not included in the Iowa Plan. Cost of prescription drugs and laboratory testing outside an inpatient care setting is paid for all enrollees through the Medicaid fee-for-service program
- Services for those diagnosed with both chronic substance abuse and chronic mental illness
- Case consultation by a psychiatric physician to a non-psychiatric physician
- Services of a licensed social worker for treatment of mental illness and serious emotional disturbance
- Psychiatric physician and psychiatric nurse evaluation and medication management services via telemedicine
- Mobile crisis services
- Mobile counseling services
- Integrated mental health services and supports
- Intensive Psychiatric rehabilitation services
- Focused case/care management
- Peer support services for persons with chronic mental illness
- Parent support services for families of children and youth with a serious emotional disturbance (SED)
- Community Support Services
- Stabilization services
- In-home behavioral management services
- Behavioral health intervention services with child and with family, including crisis intervention
- Respite services
- Reimbursement to appropriately credentialed/trained clinicians for administration of an appropriate level of functioning assessment to each Iowa Plan enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness
- Programs of Assertive Community Treatment

- Specified services to adults admitted voluntarily to a state Mental Health Institute
- Court-ordered mental health services
- Services to address the mental health needs of children in the adoption subsidy program.

Covered Services Iowa Plan IDPH-Funded and Medicaid Substance Abuse

- Outpatient services - ASAM PPC2-R Level I (Outpatient Services and Continuing Care)
- Ambulatory Detoxification without Extended On-Site Monitoring - ASAM PPC2-R Level I-D (Medicaid only)
- Intensive Outpatient - ASAM PPC2-R Level II.1
- Partial Hospitalization (day treatment) - ASAM PPC2-R Level II.5
- Ambulatory Detoxification with Extended On-Site Monitoring - ASAM PPC2-R Level II-D (Medicaid only)
- Clinically Managed Low Intensity Residential - ASAM PPC2-R III.1
- Clinically Managed Residential Detoxification - ASAM PPC2-R Level III.2-D (Medicaid only)
- Clinically Managed Medium Intensity Residential - ASAM PPC2-R Level III.3
- Clinically Managed Medium/High Intensity Residential - ASAM PPC2-R Level III.5
- Medically Monitored Intensive Inpatient (residential) - ASAM PPC2-R Level III.7
- Medically Monitored Inpatient Detoxification - ASAM PPC2-R Level III.7-D (Medicaid only)
- Medically Managed Intensive Inpatient - ASAM PPC2-R Level IV (Medicaid only)
- Medically Managed Inpatient Detoxification - ASAM PPC2-R Level IV-D (Medicaid only)
- Detoxification services including such services by a provider licensed under chapter 135B (Medicaid only)
- PMIC substance abuse services consisting of treatment provided by a substance abuse licensed PMIC and consistent with the nature and care provided by a PMIC as described in Iowa Code chapter 135H (Medicaid only)
- Emergency services for substance abuse conditions available 24 hours a day, seven days a week (Medicaid only)
- Ambulance services for substance abuse conditions which include both emergent and non-emergent situations (Medicaid only)
- Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance abuse diagnosis, identification of medical or health problems, and screening for contagious diseases
- Evaluation, treatment planning and services coordination
- All services appropriately provided as part of substance abuse treatment. Services vary according to the level of service, and may include, but are not limited to, the following:
 - lodging and dietary services
 - physician, psychologist, nurse, certified addictions counselor, social worker, and trained staff services

- rehabilitation therapy and counseling
 - family counseling and intervention for the primary client, including co-dependent/collateral counseling with primary client
 - diagnostic X-ray, specific to substance abuse treatment
 - diagnostic urine or blood testing, specific to substance abuse treatment
 - psychiatric, psychological and medical laboratory testing, specific to substance abuse treatment
 - equipment and supplies
 - cost of prescription drugs for enrollees at Level IV-D and Level IV where prescription drugs of any kind are included
- Substance abuse counseling services when provided by approved opiate treatment programs that are licensed under Chapter 125. (The costs of Bupenorphine and Methadone dispensing are not covered under the Iowa Plan.)
 - Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting OBRA 89 requirements (Medicaid only)
 - Substance abuse screening, evaluation and treatment for enrollees convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and enrollees whose driving licenses or non-resident operating privileges are revoked under Chapter 231J, provided that such treatment service meets the criteria for service necessity (Medicaid only)
 - Substance abuse treatment for IDPH participants convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and participants whose driving licenses or non-resident operating privileges are revoked under Chapter 231J, provided that such treatment service meets the criteria for service necessity and sliding fee scale
 - Court ordered evaluation for substance abuse
 - Court ordered testing for alcohol and drugs (Medicaid only)
 - Court ordered treatment which meets criteria for treatment services (except for adult Medicaid enrollees at a state mental health institute)
 - Cost of prescription drugs is not the responsibility of the Iowa Plan, except at Level IV-D and Level IV where prescription drugs of any kind are included
 - Second opinion meeting service necessity and appropriate for the enrollee's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the enrollee (Medicaid only)
 - 23-hour observation in a 24-hour treatment facility (Medicaid only).

4. Care Management

Iowa Plan-specific Care Management

Our Philosophy	Magellan is committed to members receiving the appropriate behavioral health services at the right time.
Our Policy	Magellan care managers, intensive care managers and follow-up specialists collaborate with our providers to assure optimal care for clients in the Iowa Plan. Effective outcomes can best be assured by treatment services that are consistent with the client's clinical needs. Magellan's comprehensive approach to the management of mental health and substance abuse care is clinically driven and assessment based.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none"> ▪ IN AN EMERGENCY, deliver appropriate services to the client. ▪ For reimbursement purposes, notify Magellan within 10 calendar days of an Iowa Plan Medicaid enrollee presenting with an emergency medical condition for emergency services (including emergency transportation) and not admitted to inpatient. The notification form is available on www.MagellanofIowa.com. Emergency medical conditions are defined as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. ▪ For admissions from an emergency room to a 24-hour setting or for emergency admissions directly to a 24-hour setting, you must authorize the service with Magellan after the assessment or within 24 hours of admission time. ▪ For clients that have not received Behavioral Health Intervention Services or remedial services in the past year, BHIS providers can access up to 50 units of service at www.MagellanofIowa.com by providing clinical information from a comprehensive behavioral health assessment. ▪ Services are determined to be necessary when they meet psychosocial necessity requirements for mental health and service necessity requirements for substance abuse. (See <i>Appendix A</i> for the definitions of psychosocial necessity and service necessity.) ▪ Use the appropriate Utilization Management Guidelines (UMGs) to guide care decisions as follows: <ul style="list-style-type: none"> • UMGs/Mental Health - For mental health and Iowa Plan Psychiatric Medical Institutions for Children (PMICs) services, Magellan has developed UMGs approved by Iowa-based stakeholders. The latest version can be accessed at www.MagellanofIowa.com. • UMGs/IDPH-funded and Medicaid Substance Abuse - The American Society on Addiction Medicine Patient Placement Criteria, Edition 2 -

Revised (ASAM PPC2-R) are used for substance abuse services. The ASAM criteria are available at www.asam.org.

- For Behavioral Health Intervention Services, use the appropriate UMGs. The latest version can be accessed at www.MagellanofIowa.com.
- Prior authorize Iowa Plan services by calling Magellan Care Management at 1-800-638-8820. Some services do not require prior authorization for Iowa Plan Network providers.
- For Behavioral Health Intervention Services, call us at 1-800-638-8820 to schedule a review. The professional who performed the assessment must be on the phone with the Magellan care manager for the review.

See *Appendix B* for a list of those services, which do not require prior authorization or have special authorization processes.
- Cooperate with Magellan care managers to help assure appropriate follow up within seven calendar days as part of the discharge plan for clients. It is imperative the appointments are scheduled prior to discharge from the hospital and residential/PMIC substance abuse services.
- Cooperate with reporting requirements and other agreements negotiated at the time of referral when accepting referrals for mental health and substance abuse services from DHS, Juvenile Court Services workers or adult court. Payment for such reports is included in the provider's Iowa Plan contracted reimbursement rate for the specific service being provided.
- Call Magellan when you identify clients that may require coordination in the community due to frequent hospital use or having difficulty engaging with a provider and in need of services. Call the Intensive Care Manager dedicated to your region at 1-800-638-8820. More information on intensive care management and joint treatment planning is in *Appendix C*.
- Document an appropriate discharge plan, initiated at admission and documented by discharge, in the client's clinical record. Discharge planning is a key component of effective treatment and begins when the client is admitted to services. The care manager works with providers to coordinate discharge planning for all managed services to assure continuity of care.
- Maintain clinical records in accordance with state and federal regulations.
- Coordinate Medicaid mental health services, including notification of any medication changes, with the client's MediPASS or other primary care physician and must request a release of information from the client to allow for such coordination.
- Ensure coordination of services within the bounds of confidentiality requirements. Providers must obtain an appropriate and completed release of information or authorization to disclose protected health information from each Iowa Plan client served and for each party to whom information is divulged.
- The Medicaid application which the Medicaid eligible client signed during the application process allows providers to share mental health information

with Magellan. An appropriate release of information is required to divulge substance abuse services information to Magellan.

- Assure services to hearing impaired clients through referral to another provider who can communicate with the client or by arranging for a translator. Authorization requests for a translator must be authorized through Magellan care management.
- Iowa Plan clients who are deaf or hard of hearing can access the Telephonic Device for the Deaf (TDD) by calling 1-800-787-1730. Clients also can access interpreting services through Relay of Iowa at 1-800-735-2941.
- Assure services to non-English speaking clients through referral to another provider who speaks the language or by arranging for a translator. Authorization requests for a translator must be coordinated through Magellan. As necessary, Magellan will connect the provider or client with a language line for immediate access to interpreters for over 100 languages.

What Magellan Will Do

Our responsibilities:

- Make available clinical staff familiar with your area. These staff consisting of care managers, certified alcohol and drug counselors, intensive care managers, and follow up specialists are supported by a statewide peer/family specialists and an After Hours clinical team for 24/7 response.
- Provide care management services for intakes to 24 hour and partial hospital services by a specialized intake team and After Hours team.
- Handle care management activities including pre-authorization, concurrent clinical review and Intensive Care Management, including joint treatment planning (see *Appendix C*), during normal business hours, Monday through Friday.
- Provide care management after normal business hours, Monday through Friday, and on weekends and holidays through the statewide After Hours Team.
- Provide verbal notification of authorization during each care management call. Written notification is mailed within one business day and includes the specific service authorized, the number of days or sessions authorized, and the date range for the authorization. Providers now can opt out of receiving mailed notifications and view authorizations via our website at www.MagellanofIowa.com.
- Work with the member and provider to develop a treatment plan for interim services when a member meets clinical criteria for a service but that service is not available. Interim service expectations may include: children waiting for placement or being discharged from a PMIC, members waiting for services or being discharged from inpatient psychiatric treatment, members who are waiting or returning from treatment out of state; and any member who is experiencing a mental health crisis.
- Always offer an alternate service authorization or recommendation if a non-authorization is made of a requested service.

[Non-authorizations are decisions by Magellan not to authorize requested services based on a determination of lack of psychosocial or service necessity for the requested service, lack of compliance with Iowa Plan pre-authorization requirements, or because the requested service is not in the provider's Iowa Plan contract or is not covered by the Iowa Plan. For higher levels of care, only an Iowa-licensed psychiatrist can approve non-authorization of a requested service. A Peer Clinical Reviewer is used for psychological testing, intensive psychiatric rehabilitation and targeted case management. The process of clinical reconsideration allows the provider and an Iowa Plan psychiatrist to discuss the request by telephone to assure full understanding of all clinical issues. See *Appendix D* for more information.]

5. Grievances and Appeals

Grievances and Complaints Policy

Our Philosophy	We support the right of clients and their providers acting on the client's behalf to express dissatisfaction about any matter.
Our Policy	A formal process is available for grievances from Iowa Plan enrollees and for complaints from IDPH participants. The grievance or complaint decision is the final step in the grievance/complaint process and all grievance/complaint decisions are in writing.
What You Need to Do	Your responsibilities: <ul style="list-style-type: none"> ▪ Notify enrollees, participants, or their designees that they may file a grievance or complaint either orally or in writing. Others who are not enrollees or their designees are required to initiate the process with a written request.
What Magellan Will Do	Our responsibilities: <ul style="list-style-type: none"> ▪ Resolve grievances and complaints and provide written notice of disposition within 14 calendar days of receipt of all required documentation

Appeals Process

Our Philosophy	We support the right of enrollees and their providers acting on the enrollee's behalf to appeal any action.
Our Policy	An appeal is used to request review of an action. At the time of the action, enrollees are informed of this right and how to proceed. Actions include the following: <ul style="list-style-type: none"> ▪ Non-authorization or limited authorization of a requested service, including the type or level of service; ▪ Reduction, suspension, or termination of a previously authorized service; ▪ Denial, in whole or in part, of payment for a service; ▪ Failure to provide services in a timely manner; or failure to act within the timeframes established for grievances or appeals.
What You Need to Do	Your responsibilities: <ul style="list-style-type: none"> ▪ Refer to the Notice of Action for specific procedures for appealing an Action. ▪ An appeal must be filed either orally or in writing to Magellan within 30 days of Magellan's written Notice of Action. An oral request to appeal must be followed by a written, signed, appeal. ▪ If taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain

maximum function, an expedited appeal may be requested.

- Within 30 days of the written notice of resolution, a provider, on behalf of an enrollee, may request a State Fair Hearing, often referred to as an Administrative Law Judge (ALJ) hearing, if dissatisfied with Magellan's Appeal resolution. This falls under the provisions of the 441 Iowa Administrative Code Chapter 7.
- When a request for hospital inpatient care is non-authorized and Magellan offers an alternative authorization, the provider may choose to serve the enrollee at the higher level of care and request an Appeal for reimbursement at the contractual rate of the offered alternative authorization. To be considered for alternative reimbursement, the hospital must be contracted to provide both the requested level of care and the offered alternate service.

What Magellan Will Do Our responsibilities:

- Notify you verbally of a non-authorization determination and the appeal process, to be followed up by a written Notice of Action within 10 business days.
- Acknowledge receipt of each appeal request.
- Ensure that oral inquiries seeking to appeal an Action are treated as appeals and confirm those inquiries in writing upon receipt of the written, signed appeal, unless the enrollee or the provider requests expedited resolution.
- Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Complete all appeals by individuals with appropriate clinical experience who have not been previously involved in the decision.
- Complete standard appeals with written notification sent within 45 calendar days of the request.
- Extend the timeframe by up to 14 days if the enrollee requests the extension or with approval by DHS, when it is shown that there is need for additional information and when the delay is in the enrollee's interest.
- Honor the enrollee's right to request to continue to receive benefits pending an appeal or State Fair Hearing determination when all the following conditions are met:
 - a) The appeal or State Fair Hearing is filed within 10 calendar days of the written notice from Magellan of an adverse appeal determination;
 - b) The appeal involves the termination, suspension, or reduction of a **previously authorized** course of treatment;
 - c) The services were ordered by an authorized provider;
 - d) The original authorization period has not expired; and

- e) The enrollee requests the extension of benefits.

The enrollee's right to continue to receive benefits until one of the following occurs:

- a) The enrollee withdraws the appeal or request for the State Fair Hearing;
- b) Magellan's issues an adverse decision on the appeal and the enrollee does not request a State Fair Hearing within 10 calendar days from receipt of the decision; or
- c) The authorization expires or authorization service limits are met.

The enrollee's responsibility to pay the cost of the services furnished to the enrollee while the appeal or State Fair Hearing was pending if the final resolution of the appeal or State Fair Hearing is adverse to the enrollee, but only to the extent that these services were furnished solely because the enrollee requested a continuation of benefits.

- Complete expedited appeals with written notification sent and reasonable efforts to provide oral notice within 72 hours of the request.
- When a Magellan action is modified or overturned by an Appeal resolution or State Fair Hearing decision, Magellan reimburses providers in accordance with Iowa Plan policies and with the contract between Magellan and the provider in effect for those dates of service. New claims submission is required if an appropriate claim was not previously submitted for those dates of service. No reimbursement is made if the Appeal resolution or State Fair Hearing decision upholds Magellan's action.

Compliment Submission

Our Philosophy	We support the ability of Iowa Plan stakeholders to file a compliment if they are pleased with something related to the Iowa Plan.
Our Policy	A formal process is available for compliments from Iowa Plan enrollees, IDPH participants, and other stakeholders.
What You Need to Do	Compliments may be filed by phone or in writing to any Iowa Plan staff.
What Magellan Will Do	Magellan staff will accept your compliment, record it, and report it as appropriate.

6. Provider Reimbursement

Provider Reimbursement – Professional Services

Our Philosophy	Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.
Our Policy	Magellan reimburses Iowa Plan Medicaid behavioral health and substance abuse treatment providers in accordance with reimbursement schedules for professional services. The reimbursement schedules contain current procedural terminology (CPT) codes for traditional outpatient providers, and a combination of CPT and Healthcare Common Procedure Coding System (HCPCS) codes. The reimbursement schedule(s) is attached to your Magellan provider agreement.
What You Need to Do	<p>For Iowa Plan Medicaid Services and Claims</p> <p>Your responsibility is to:</p> <ul style="list-style-type: none"> ▪ Verify Iowa Plan member eligibility either via www.MagellanofIowa.com or by calling the Iowa Care Management Center at 1-800-638-8820. Reimbursement is contingent upon the client being enrolled in the Iowa Plan on the date(s) of service. ▪ Seek authorization for all levels of care which require authorization. Some outpatient services do not require authorization, and some have special authorization processes. (See <i>Appendix B</i>). ▪ Notify Magellan within 10 days of service delivery of emergency room (ER) services for Iowa Plan Medicaid clients. This notification should include pertinent clinical information. To be reimbursable, the diagnosis must be an Iowa Plan covered diagnosis. If notification is not received within 10 days, Magellan reimburses an ER triage fee only. This fee is consistent with the triage reimbursement offered through the Medicaid fee-for-service program to determine whether an emergency exists. ▪ Notify Magellan within 10 days of service delivery of emergency transportation services for Iowa Plan Medicaid clients. This notification should include pertinent clinical information. To be reimbursable, the diagnosis must be an Iowa Plan covered diagnosis. If notification is not received within 10 days, Magellan reimburses an ER triage fee only. This fee is consistent with the triage reimbursement offered through the Medicaid fee-for-service program to determine whether an emergency exists. ▪ Coordinate the use of translators through Magellan. Magellan pays for authorized translator services. ▪ To be reimbursed for services to Month Of Application (MOA) clients who gain Iowa Plan enrollment, providers must follow all Iowa Plan care management and other requirements that apply to the service(s) the client receives. Providers may submit claims for services to MOA clients once Iowa Plan enrollment has been verified. Claims submitted prior to enrollment verification are denied and returned to the provider. ▪ When inpatient, subacute or partial services are authorized for an Iowa

Plan client, the attending psychiatrist is included in the authorization. It is understood that psychiatrists may share on-call or other coverage. The psychiatrist who delivers the care on a particular day of service is reimbursed. If the psychiatrist who delivers care on a particular day of service is not the attending psychiatrist listed on the authorization, the claim for the service must include the name of the psychiatrist delivering the service and the name of the authorized psychiatrist.

- Claims for the first 12 mental health visits to a primary care physician in one calendar year for a mental health code should be submitted to the Iowa Medicaid Enterprise (IME) for payment. Magellan reimburses non-psychiatric physicians for mental health office visits in excess of 12 office visits per Medicaid client per calendar year. The Medicaid fee-for-service system allows reimbursement to non-psychiatrist physicians for 12 visits for mental health purposes. The thirteenth visit must be submitted to the IME for denial. Physicians should submit the denial notice from the IME to Magellan with the CMS 1500. Claims for visits subsequent to the thirteenth visit may be sent directly to Magellan. Evaluation and Management codes may be used for billing.
- When a third party (other health insurance) is responsible for payment of all or part of a client's services, providers must bill the third party first and then submit the claim with the other payor's Explanation of Benefits to Magellan for any additional amount(s) payable under the Iowa Plan. When the third party is Medicare, Magellan is responsible for those Iowa Plan services not covered by Medicare. Any remaining charges after Medicare payment should be submitted to the IME.
- Designated Targeted Case Managers (TCMs) are reimbursed for targeted case management services to chronically mentally ill Iowa Plan Medicaid clients. TCMs may bill services electronically or by using the Targeted Case Management Billing Form or CMS 1500.
- Sign up for online claims submission and electronic funds transfer (EFT) through www.Magellanoflowa.com.
- Prepare claims in accordance with industry standards for the coding of behavioral health services.
- Prepare claims for professional services which have differing reimbursement amounts by level of licensure using the appropriate modifier for the level of the practitioner providing the service.
- Submit a clean claim form for the services that you have provided through www.Magellanoflowa.com, via Direct Submit, through an accepted clearinghouse, or via paper claim.
- Use the proper address for submitting claims. The address for Iowa Plan Medicaid claims is:

Magellan Health Services
P.O. Box 1869
Maryland Heights, MO 63043

- In accordance with state requirements, Magellan requires Medicaid

claims to be resolved by the 365th calendar day from the date of service.

- Magellan encourages providers to submit claims within 60 calendar days of date of service or discharge; however, claims will not deny until 366 calendar days from date of service or discharge.
- Bill using your contracted Taxpayer Identification Number.
- Hold the enrollee harmless and do not bill the enrollee for any amount of any service covered by the Iowa Plan, including the difference between Magellan's reimbursement amount and your standard rate. This practice is called balance billing and is prohibited.
- Contact the Iowa Care Management Center at 1-800-638-8820 if you are not certain which services require pre-authorization, what your reimbursement rate is, or for any questions that you have concerning the client in care.

For Iowa Plan IDPH-Funded Substance Abuse Services

Your responsibility is to:

- Ensure that clients receiving IDPH-funded services cost-share on the basis of a sliding fee scale that considers individual/immediate family income and family size.
- Determine client eligibility for IDPH-funded services.
- Meet the contractual minimum client numbers and service mix requirements in your contract. Provider funding is tied to a minimum number of clients the provider must serve. Provider reimbursement may be reduced if minimum client numbers and/or service mix requirements are not met.
- Ensure that IDPH funds are used as the "payment of last resort," since they are intended to support those Iowa residents without resources to pay for substance abuse services or having available third party resources to pay for services. Providers must apply all available funding from third party payors prior to determining a client's eligibility as a IDPH-funded client. When all third party fees have been determined, eligibility for IDPH funding can be determined and, if the client is eligible, the sliding fee scale can be applied to the client's portion of the remaining fees.
- For IDPH participants only, providers may bill the participant for one "no-show fee" for a missed appointment during each distinct episode of care. A distinct episode of care is defined as the course of treatment that occurs with one provider, from assessment through admission and subsequent service(s), ending at discharge.

What Magellan Will Do Magellan's responsibility to you is to:

- Provide a toll-free number for you to call for provider assistance (1-800-638-8820).
- Respond to your questions and help resolve issues.
- Process your Iowa Plan Medicaid claims in a timely manner.

- For enrollees, pay for physical examinations for patients admitted for mental health or substance abuse reasons to an inpatient setting, when the inpatient admission has been authorized according to Iowa Plan care management policies.
- Communicate changes to your contract at least 30 days prior to the effective date, unless the change is required by statute or is a regulatory requirement. The 30-day notification may be waived if it is to the benefit of the provider.
- Reimburse you for IDPH-funded substance abuse services on a prospective basis. The funding allocation is defined by the contract currently in force between Magellan and the active Iowa Plan IDPH-funded provider.
- Vigorously enforce National Correct Coding Initiative (NCCI) edits as outlined by CMS for the reimbursement of Medicaid services, and apply the intent of these edits to Behavioral Health Intervention Services (BHIS).

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7. Contracting and Credentialing

Please see Magellan's National Provider Handbook for full descriptions of our contracting and credentialing processes. See *Appendix E* for Professional Criteria and Medicaid Reimbursable Outpatient Services by Professionals specific to the Iowa Plan and for credentialing criteria for providers of Behavioral Health Intervention Services (BHIS).

This section addresses Iowa plan-specific information regarding IDPH-funded substance abuse providers.

Role of the Provider and Magellan –IDPH-funded Substance Abuse Providers

Our Philosophy	Magellan is committed to ensure that Iowa residents that are at or below 200% of the federal poverty level who are not Medicaid enrollees receive substance abuse services as directed by the Iowa Department of Public Health (IDPH).
Our Policy	Magellan will work with IDPH to issue an open competitive request for proposals (RFP) process that will ensure the full continuum of IDPH-funded substance abuse services.
What You Need to Do	Your responsibility is to: <ul style="list-style-type: none"> ▪ Be licensed or accredited by the IDPH Division of Behavioral Health as a substance abuse treatment program. ▪ Maintain a not-for-profit organizational status ▪ Agree to the terms of the Iowa Plan contract including state and federal Substance Abuse and Treatment Block Grant requirements. ▪ Report services provided to IDPH participants using the reporting system identified by IDPH.
What Magellan Will Do	Magellan's responsibility to you is: <ul style="list-style-type: none"> ▪ To monitor and document provider activities to ensure that the IDPH-funds are spent according to all federal and state requirements.

8. Client and Family Participation

Participation Overview

Clients and their family members bring a unique and personal perspective to service delivery. While advocacy groups effectively represent their constituents, special efforts are made to assure input from Iowa Plan clients and their families.

Iowa Plan clients have the right to:

- Be treated with respect and with consideration of their dignity and privacy.
- Be treated fairly regardless of their race, religion, gender, ethnicity, disability or source of payment.
- Have their treatment and other information kept private and confidential. Records may be released without their permission **only** where permitted by law.
- Easily get care in a timely fashion.
- Receive information on treatment options and alternatives in a way that is appropriate to their condition and easy to understand.
- Share in developing your plan of care.
- Receive interpretation services at no cost to them. They also have the right to receive information in a language they can understand. Information is available in other formats if they request it.
- Receive information about Magellan, its practitioners, programs, services, and role in the treatment process.
- Receive information about the clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Not be restrained or secluded to make them do something that they do not want to do (as specified in federal regulations on the use of restraints and seclusion).
- Give input on the Magellan's Rights and Responsibilities policy.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Be given health care services that obey federal and state laws that have to do with their rights.
- Participate in decisions regarding their health care. This includes the right to receive a second medical opinion and the right to refuse treatment (except when it is ordered by the court).
- File a complaint/ grievance about Magellan, a provider or the care they received.
- File an appeal about a Magellan action or decision. They also have the right to request a State Fair Hearing (Medicaid only, not IDPH) if they are not satisfied with the result of an appeal.
- Request and receive a copy of their medical records. They can also request that they be changed or corrected.
- Exercise their rights. If they do this it will not affect the way Magellan and its providers treat them.
- Receive written information on advanced directives and their rights under state law.
- Have candid discussions with their provider about appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage.

Client and Family Involvement in Treatment Planning

Client involvement in treatment planning, particularly joint treatment planning, can contribute to recovery and improved outcomes. Magellan has the parent/guardian or adult client present during Joint Treatment Planning Conferences.

Peer Specialist/Family Advocate

Peer Specialists and Family Advocates discuss issues and topics of interest with persons around the state. They liaison with Care Management to support families in seeking and maintaining appropriate treatment. They ensure communication between those who receive services and those who implement and operate the Iowa Plan.

Contact the Peer Specialists and Family Advocate at 1-800-638-8820.

Meetings and Roundtables

Magellan assures client and family input into the Iowa Plan through local, regional, and statewide roundtables and other organized meetings as well as informal discussions with mental health and substance abuse clients, their family members and significant others.

The Iowa Plan Recovery Advisory Committee (previously known as the Consumer and Family Advisory Committee) assures input into Iowa Plan operations from the perspective of clients and their family members.

Examples of roundtables and other meetings with opportunities for consumer/family input include, but are not limited to:

- Quality Improvement Committee
- Iowa Plan Advisory Committee
- Recovery Advisory Committee
- 65+ Stakeholder Circle
- Peer Support Roundtable
- Women and Children's Roundtable.

9. Quality Improvement

Please see Magellan's National Provider Handbook for full descriptions of our corporate quality improvement philosophy and program. This section addresses Iowa Plan-specific information regarding quality.

Client Access to Care

Our Philosophy	Clients have timely access to appropriate mental health and substance abuse services 24 hours a day, seven days a week.
Our Policy	Magellan will assure that clients have appropriate access to covered mental health and substance abuse services reflecting the clinical urgency of their situation.
What You Need to Do	<p>Your responsibilities:</p> <ul style="list-style-type: none"> ▪ Provide access to services 24 hours a day, seven days a week; ▪ Inform clients of how to proceed should they need services after business hours; ▪ Provide coverage for your practice when you are not available, including, but not limited to, an answering service with emergency contact information; ▪ Respond to telephone messages in a timely manner; ▪ Ensure services for emergency needs are provided within 15 minutes of presentation at a service delivery site; ▪ Ensure services for mobile crisis needs are provided within one hour of presentation or request; ▪ Ensure services for urgent non-emergency needs are provided within 1 hour of presentation at a service delivery site or within 24 hours of contact with your organization and/or referral from Magellan; ▪ Ensure services for persistent symptoms are provided within 48 hours of reporting symptoms; ▪ Ensure services for routine needs are provided within four weeks of the request for an appointment; ▪ Ensure clients who are pregnant women in need of routine substance abuse services be admitted within 48 hours of seeking treatment (IDPH-funded services); ▪ Ensure clients who are intravenous drug users be admitted not later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request (IDPH-funded services); and ▪ Ensure priority in admissions to IDPH-funded treatment is as follows: <ul style="list-style-type: none"> • pregnant women injecting drug users

- pregnant substance abusers
 - injecting drug users
 - all others.
- What Magellan Will Do**
- Communicate the clinical urgency of the consumer’s situation with providers
 - Assist with follow-up service coordination for consumers transitioning to another level of care from an inpatient stay
 - Establish a program of assertive provider outreach to rural areas where mental health or substance abuse services may be less available than in more urban areas
 - Monitor utilization in regions across the state and in rural and urban areas to assure equality of service access and availability.

Collaboration on Focused Quality Studies

Our Philosophy	We strongly believe in and actively work toward continuous quality improvement.
Our Policy	In order to provide high quality, coordinated services to Iowa Plan clients, Magellan needs to be able to collaborate with providers on various focused quality studies.
What You Need to Do	Providers need to be willing to participate in a variety of focused quality studies when asked by Magellan staff. These may be short-term inquiries or longer-term projects.
What Magellan Will Do	Magellan will offer information, technical assistance, and training on the areas involved in the quality studies. Expectations will be made clear and a collaborative approach will be taken with all focused quality studies.

<i>Coordination of Medications & Medication Screening</i>
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Our Philosophy	We believe it to be imperative to provide coordination of medications and medication screening to Iowa Plan clients.
Our Policy	Providers are required to coordinate and communicate with Primary Care Physicians regarding clients' medications and to document specific information about medication in the clinical record.
What You Need to Do	<p>Providers must document in the treatment record the coordination of care regarding medication with any other physician providing services to the client. Providers must document the following in the clinical record at admission and as appropriate throughout treatment:</p> <ul style="list-style-type: none"> ▪ Known drug allergies or lack of allergies ▪ Whether the consumer is pregnant ▪ Medications the consumer is currently taking ▪ Medications prescribed, including the dates of the initial prescription and any refills ▪ Medication instructions to consumers at the time of prescribed changes in medications ▪ Adverse reactions to medication changes and medical status ▪ Medication instructions when discharged from an inpatient setting.
What Magellan Will Do	Coordination and screening is monitored through the care management process and through on-site retrospective reviews of treatment records.

Provider Profiling

Our Philosophy

When collected and analyzed in a reliable and consistent manner, provider profiling information can positively impact quality of care.

Our Policy

Quarterly provider-specific profile reports include a multi-dimensional assessment of each provider's performance using indicators which address demographic information, clinical quality and outcomes, access, utilization management, application of principles of recovery and resiliency, pharmaceutical management, linkage with primary care physicians, and clinical record-keeping.

Profiling reports will be produced for a threshold of high-volume providers that meets contract requirements, supports statistically valid results, and provides sufficient protection against identification of consumers whose data make up the profile.

What You Need to Do

Your responsibilities:

- Providers are expected to utilize the profile reports for internal quality improvement practices.
- Compliance with provider profiling analysis and follow-up are a contractual requirement for Iowa Plan providers. Specific corrective action plans and timelines are developed in partnership with providers, as necessary.
- Providers are encouraged to accept invitations to participate in collective quality improvement initiatives around the profiling data and reports.

What Magellan Will Do

Our responsibilities:

- Profile reports will be made available in an easy-to-use format on a quarterly basis.
- Identify opportunities for improvement and meet with the highest volume providers at least twice each year to establish quantitative performance improvement goals and track provider attainment of goals.
- Provide technical assistance to providers, as needed based on assessment of a provider's performance or upon request.
- Take appropriate action with those providers whose performance has failed to improve pursuant to the terms of the provider's improvement goals – action may include suspending the provider's ability to expand services, suspending the provider's ability to see new Iowa Plan consumers, and/or contract termination.

10. Additional Requirements

Role of the Provider and Magellan—Other Requirements

Our Philosophy	Magellan is committed to ensure that all of the Iowa Plan clients receive services in a safe environment.
Our Policy	Magellan staff is trained to enforce requirements that providers must adhere to based on a variety of public laws, and State and Federal rules.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none"> ▪ Comply with the blood-borne pathogen standards published December 6, 1991, in the Federal Register by the United States Occupational Safety and Health Administration (OSHA). ▪ Comply with the Drug Free Workplace Act of 1988 and 41 U.S. section 701, and report any conviction of employees under a criminal drug statute for violations occurring on the provider's premises or off the provider premises while conducting official business. A report of a conviction shall be made to Magellan within five (5) working days after the conviction. ▪ Follow Public Law 103-227 (Pro-Children Act of 1994) that requires that smoking may not be permitted in any portion of any indoor facility owned or leased or contracted by an entity used routinely or regularly for the provision of Iowa Plan services. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities other than clinics where WIC coupons are redeemed. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to \$1,000 each day. ▪ Perform outreach activities to IV drug users. You shall select, train and supervise outreach workers: encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. ▪ Ensure early intervention services for HIV disease to individuals will be undertaken voluntarily by and with the informed consent of the individual. Undergoing such services is not to be required as a condition of receiving treatment services for substance abuse or any other service. ▪ Offer continuing education to staff providing treatment services or activities. This shall include education on confidentiality requirements and information on disciplinary action relating to the requirements.
What Magellan Will Do	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"> ▪ Provide on-going support and monitoring of these requirements in order to help with your compliance and aid with any technical assistance.

IDPH-Funded Services

Our Philosophy	Magellan Behavioral Care of Iowa is committed to ensuring that IDPH participants receive appropriate care and ancillary services.
Our Policy	Magellan requires that all IDPH-funded providers meet all of the contractually required block grant requirements.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none"> ▪ Make available tuberculosis (TB) services directly or through a collaborative agreement with another local agency. Implement infection control procedures and protocols provide by the Departments. All programs shall test for TB in the following populations: <ol style="list-style-type: none"> 1. All persons in residential treatment and half-way houses; and 2. Recipients of outpatient services who are: <ol style="list-style-type: none"> a. IV drug users; or, b. persons who are in a close relationship with IV drug users and, c. any other clients who may be at high risk for tuberculosis, such as those with an unexplained persistent cough or the homeless. ▪ Provide an AIDS Education Component to treatment clients. The component shall include information regarding optional AIDS virus testing. Pre- and post-test counseling shall be made available to clients to be tested for the virus. ▪ Agree that the Auditor of the State of Iowa or any authorized representative of the State, and where Federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States Government, shall have access to, and the right to examine, audit, excerpt and transcribe any pertinent books, documents, paper, and records of the provider related to order, invoices, or payments of this contract. ▪ Agree that the Departments or their authorized representatives may have access to medical records and quality assurance materials for purposes of an independent audit of quality assurance and quality of care. ▪ Report services to all substance abuse clients, regardless of the client's payment source, using IDPH's Iowa Service Management and Reporting Tool (I-SMART). <i>For information specific to I-SMART reporting, consult the SARS Manual or contact the DPH Division of Behavioral Health and Professional Licensure at 1-515-281-4643.</i> ▪ Providers submit I-SMART data to IDPH. IDPH sends I-SMART data to Magellan. Magellan processes specific I-SMART data and sends summary information to providers and to IDPH. I-SMART reporting is monitored to assure services are accurately documented. ▪ Providers receiving IDPH funding are considered Subrecipients of the

Substance Abuse Prevention and Treatment Block Grant. Subrecipients of Federal funds are required to have an audit made in accordance with the provisions of OMB Circular A-128, Audits of State and Local Governments or OMB Circular A-133, Audits of Institutions of Higher Education and other Non-Profit Institutions. A copy of audit reports acquired and subject to OMB Circulars A-128 or A-133, State regulations or otherwise required, shall be forwarded to Magellan upon receipt and at no charge. The provider may be required to comply with other prescribed compliance and review procedures. Magellan reserves the right to refuse payment for audit services which do not meet Federal or State requirements. Audits are due within nine months following the end of the period covered. Upon completion of the audit, a press release shall be published to announce the availability of the audit report for review by the public at the provider's office. The press release shall be provided to a local newspaper with a copy sent to Magellan and a copy maintained in the provider's office.

- Submit one copy of the audit report to Magellan within 30 working days of its issuance, unless specific exemption is granted. The audit shall be scheduled so that an audit report will be received by Magellan no later than nine months following the end of the contract period. To be submitted with the audit is a copy of the separate letter to management addressing non-material findings, if provided by the auditor.
- Make every reasonable effort to link clients in needed wrap around services such as criminal justice, education, vocational rehabilitation and employment. Written referral and/or collaborative agreements are to be maintained.
- Provide documentation that the provider or organization has coordinated its services with other local entities providing similar services.
- Ensure that services under this contract are for Iowa residents only. The primary place of residence at the time of treatment must be in Iowa. If a place of residence is not maintained while receiving residential or halfway house services, the most recent place of residence will be considered when determining residence.
- Develop other sources of financial support for program activities, including the following activities:
 1. Recover, to the maximum extent feasible, third-party revenues to which the provider is entitled as a result of services provided;
 2. Garner all other available federal, state, local and private funds;
 3. Charge beneficiaries according to their ability to pay for the services provided, based on a sliding fee schedule. The sliding fee schedule shall be based on standardized guidelines provided by IDPH. Variances from these guidelines must have prior written IDPH approval. Client billing and collection procedures shall be consistent

- with those established and provided by IDPH. Services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Factors of individual/immediate family income and family size are to be used in developing the sliding fee schedule; and
4. Report to Magellan within five working days, funding sources developed in addition to those shown in the application for funding.
- Use federal funds made available under this contract to supplement and increase the level of state, local and other non-federal funds that would in the absence of such federal funds be made available for the programs and activities for which funds are provided and will in no event take the place of state, local and other non-federal funds.
 - Maintain your organization's status as a non-profit organization pursuant to Iowa Code chapter 504A (Iowa Non-profit Corporation Act) or its affiliation with a government organization, and file all required state and federal reports to maintain such status.
 - Perform outreach activities to IV drug users. The providers shall select, train and supervise outreach workers. They shall encourage individuals needing IV treatment to undergo treatment and provide awareness about relationship between IV use and communicable disease. The provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonable effective.
 - Ensure that IDPH funds, as provided by this contract are to be use as "payment of last resort" (i.e., all other available funds used prior to billing funds available through this contract).
 - Ensure that priority in treatment is given to those individuals with the greatest clinical need. In establishing clinical need, priority must be given to substance abuse which results in the highest personal and social cost as measured by severity of personal and social consequences, and the number of abusers. Pregnant women are to be given preference in admissions to treatment as follows: (1) pregnant women injecting drug users, (2) pregnant substance abusers, (3) injecting drug users, (4) all others. Admission to treatment of pregnant women must be accomplished within 48 hours and intravenous (IV) drug users within 14 days of the individual seeking treatment. If the provider is unable to admit the pregnant women or IV drug user within the required time due to insufficient capacity, Magellan is to be notified immediately, using procedures established by Magellan. In addition, Magellan is to be notified when treatment program networks reach 90 percent capacity to admit clients.
 - Maintain property records on equipment in accordance with 45 CFR Part 92.32. Equipment means tangible, non expendable, personal property having a useful life of more than one year and an acquisition cost of \$5000 or more per unit. A provider may use its own definition

of equipment. Property records must be maintained that include the following:

- a description of each item purchased
 - a serial number or other identification number
 - the location and condition
 - the acquisition date
 - the acquisition cost
 - current market value
 - disposition of the equipment
- If, after notifying Magellan that admission to treatment of pregnant women can not be accomplished within 48 hours or IV drug users within 14 days of the individual seeking treatment, it is determined that no provider has capacity, interim services are to be provided. Interim service to IV drug users shall include counseling and education about HIV and TB, about the risks of transmission to sexual partners and infants, about relationship between IV use and communicable diseases, and about steps that can be taken to ensure that HIV transmission does not occur and, if necessary, referral for HIV and TB treatment services. The provider shall establish a waiting list, which includes a unique patient identifier, for individuals awaiting treatment for IV drug use, including those receiving interim services. For pregnant women this shall also include prenatal care referral and affects of alcohol and drug use on the fetus.
- Ensure that contract funds are expended only for services and activities covered in this contract. Unless specifically allowed by special condition, IDPH contract funds may not be expended for the following:
- Purchase of land or construction of building or improvements thereon, or payment of real estate mortgages or taxes.
 - Purchase of major medical equipment.
 - Costs related to political activity.
 - Any bonus, commission or fee paid by the provider for the purpose of applying for or obtaining an Iowa Plan contract.
 - Distribution of sterile needles for the hypodermic injection of any legal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection.
 - Carrying out testing for the etiologic agent for acquired immune deficiency syndrome unless such testing is accompanied by appropriate pre-test and post-test counseling.
 - Any salary in excess of \$125,000 per year.
 - Cost of services that are paid for by another organization or individual.

- Inpatient hospital treatment.
- Satisfying the requirement for expenditures of non-federal funds as a condition for the receipt of federal funds.
- Subcontracting for treatment services by organizations other than government or private non-profit entities.
- Payments to intended recipients of health services.

What Magellan Will Do Magellan's responsibility to you is to:

- Respond to your questions, help resolve issues and provide a toll-free number for you to call for provider assistance (1-800-638-8820).
- Communicate changes to any requirements at least 30 days prior to the effective date, unless the change is required by statute or is to the benefit of the provider, in which case the 30-day notification may be waived.