VII. Report of the Regionalization Workgroup

A. Introduction

The purpose of this chapter is to summarize the recommendations of the Regional Workgroup formed as part of the MHDD redesign effort to provide input and recommendations to the Legislative Interim Committee pursuant to SF 525.

Based on discussions of the Workgroup, including Legislators and state officials, the goals of the regionalization redesign effort include:

- Improve and clarify the methods and entry points by which consumers and families can request and access services.
- In the context of available resources, assure equity of access to core services for all citizens of the state of Iowa.
- Assure consistency of service access and provision throughout Iowa, while also maintaining the value of locally designed and operated systems of care for people across the lifespan with MH, ID-DD service needs.
- Assure high quality and continuous quality improvement of services within the systems of care for people with disabilities.
- In the context of available resources, foster the implementation of evidence based and promising best practices known to produce the most positive outcomes for consumers and their families.
- Assure accountability, efficiency, and proper stewardship of public resources in the system.

The Regional Workgroup has met five times since the enactment of SF 525[1]. The recommendations summarized below have been derived directly from the discussions and consensus-building that occurred during these meetings. Much of the material presented below originated in the materials and discussion papers prepared for the Workgroup, and the consensus recommendations are already reflected in the minutes of the meetings.

B. Why Regions?

The first meeting opened with an overview of SF 525 and a summary of expectations for the Workgroup from DHS and Legislators. This triggered an extensive discussion of the benefits that could be derived from regions and the possible risks or downsides of forming regions. The consensus of the Workgroup with respect to pros and cons of regions is summarized in Table One below.

1 August 16, August 30, September 27, October 11th and October 25th

Table One: Summary of the Potential Pros and Cons of Regions

Why Regions: Pros	Why Not Regions: Cons
• Create economies of scale so that scarce resources can be better used for things that consumers and their families really want. • Assure easy and equitable access to an array of core services. • Simplify navigation of the system for both consumers and providers – no wrong door. • Provide a clear locus of responsibility and accountability for the quality and effectiveness of services. • Reduce complexity and inefficiency in the system. • Reduce the duplication of administrative systems and resources. • Increase the degree of consistency in service access, delivery and funding throughout Iowa. • Maintain the value and effectiveness of local connections and relationships with other systems of importance to consumers and families. • Be respectful and responsive to geographic differences within the state. • Improve data collection and reporting.	• Create another layer of bureaucracy. • Create further distance between primary consumers (and their families) and the service system that is supposed to be responsive to their needs and choices. • Create geographic or transportation barriers to accessing services. • Overlook or overpower the tradition of home rule and local county commitment to services. • Create regional barriers or differences in service access and delivery that are similar to those that now exists with the county-based system.

The Workgroup agreed that this list of the potential benefits and risks of forming MHDD regions could be used as a template for assessing recommendations from the group. That is, for each topic discussed and each consensus recommendation reached, the Workgroup would assess the degree to which the potential benefits of regions could be enhanced, while the potential downsides could be mitigated.

C. Criteria for formation of Regions

SF 525, and the Legislative history leading up to SF 525, provides substantial guidance related to criteria for the potential formation of regions. The criteria for regions summarized below are a synthesis of criteria already included in SF 525 plus additional criteria determined by the group to (a) be consistent with Legislative intent; and (b) strike a reasonable balance between the benefits of local knowledge, relationships, and personal contact with consumers and other stakeholders with the need to attain equity, consistency and economies of scale.

Recommended Criteria for the formation of regions:

1. The target population for regions should be in the range of 200,000 to 700,000 total people.
2. Per SF 525, there must be the presence of or assured access to inpatient psychiatric bed capacity for the citizens of each region.
3. Per SF 525, there must be a state-certified CMHC or a FQHC that provides behavioral health services within each region.
4. Per SF 525, regions must be comprised of contiguous counties.
5. There must be no fewer than three counties per region. (There will be no single county regions.)
6. There is no upper limit on the number of counties that can be included in a region.
7. There will be no specific criteria for minimum travel times or distances to administrative offices within a region (although such factors will have to be addressed in a region's management plan).

The Workgroup assumed that the application of these criteria would result in a total of five to 15 MHDD regions in Iowa. This is believed to be consistent with the intent of SF 525.

D. Governance and Financial Management

The Regional Workgroup recognized that governance and financial management are critical to the successful formation, sustainability and accountability of regions. The Workgroup also understood that changes in the financing of the MHDD system could alter the types of governance and funds management options appropriate for regions. For the purposes of the Workgroup discussion, it was assumed that (a) the authority for county levy funding for MHDD would be continued; and (b) county elected officials (Supervisors) or their designees would form and have majority control of the governing boards of regions.

The following is a brief summary of consensus recommendations reached after extensive discussions over the course of two meetings of the Workgroup:

Regional Governance

- There was consensus, as noted above, that the governing boards of counties would be comprised of Supervisors (or their designees) from each of the counties included in a region. Each participating county would have one Supervisor (or designee) identified to serve on the board of the region.
- There was consensus to support the "one county-one vote" principle for the regional governing boards, and to not attempt to have proportional or weighted voting among the counties participating in regions. This was done in recognition that all counties, regardless of size, have an equal stake in the success of regions while continuing to represent the interests and priorities of their local citizens.
- There was consensus that the governing body for each region should have at least three consumer/family members on the board. The method of selection/appointment could be spelled out in each region's 28E agreement. The Workgroup emphasized that the regional board and 28E agreement should emphasize balanced representation of consumers and families from among the different disability groups receiving services under the auspices of the regions.

- There was discussion of whether DHS or another representative of the state should have a seat on the governing boards of the regions. The consensus is that because the state will enter into and enforce performance contracts with the regions, it should not also have a seat on the governing boards.
- There was consensus that providers should have an active role in advising Regions in service system planning, implementation and quality improvement, but that providers should not be included in the governing boards. It should be noted that one Workgroup member made cogent arguments for including at least one provider on the governing board. The basis for that position is (a) that providers are increasingly important partners with the MH/ID-DD system as a whole and the Counties/Regions in particular; and (b) that national health reform models of provider-sponsored accountable care organizations and health homes provide models for the roles of providers in the leadership and governance of systems of care. It was suggested that the provider council established by each region could nominate a provider to serve on the governing board. However, the majority of Workgroup members maintain the position that providers should not be included as voting members of the governing boards.
- There was consensus that 28E agreements governing regions could either support creation of a new organizational entity or could cement a regional consortium of participating counties. The suggested topic areas to be covered by 28E agreements are listed below.

Regional financial management

- There was consensus that the regions should utilize a single "checking account" into which county levy funds[2] would be deposited and from which county levy funds would be spent. It was agreed that maintaining separate accounts for county levy funds within each county was inefficient and could increase "transactional friction". This consensus was reached after much discussion of various options, and is based on the ability of regions to use information technology to report expenditures by consumer, service and provider at the county level. This transparency of reporting will allow each participating county to maintain stewardship of locally-levied funds for MHDD services.

Topics for 28E agreements

This list of topics is derived from (a) a review of the current Iowa statute governing 28E agreements; (b) the 28E agreement now in force for the one fully-functional multi-county MHDD region in Iowa (County Social Services); and (c) examples of similar inter-local agreements from other multi-county jurisdictions in other states.

- Purpose: the goals and objectives of entering into the interlocal agreement.

2 Plus state funds allocated to the regions and any other sources of revenues.

- Identification of the single point of accountability for the region: the governing board and its executive.
- Parties to the agreement: list of counties participating in this particular 28E agreement.
- Term: how long is the agreement to be in force, and on what time frames will it need to be renewed? (For example, if there are sunset provisions in the statute, will the interlocal agreement sunset at the same time?)
- Methods for adding new participants: on what basis and under what circumstances will the initial partners admit one or more addition counties to the agreement?
- Governing Board: membership, terms, methods of appointment, voting procedures, etc.[3]
- Formation and use of consumer/family and provider advisory councils.
- Executive function: role of the Governing Board in appointing and evaluating the performance of the chief executive of the region, specification of functions and responsibilities of the executive.
- Specification of functions: (a) to be carried out by each of the partners in the agreement; and (b) to be carried out via sub-contract with external parties (does not include provider network contracts).
- Methods for funds pooling, management and expenditure.
- Methods for allocating administrative funds and resources.
- Contributions and uses of any start-up funds or related contributions made to the region by the participating counties.
- Methods for acquiring and/or disposing of property.
- Process for deciding on the use of savings for reinvestment.
- Process for annual independent audit.
- Method(s) for dispute resolution and mediation.
- Method(s) for termination of the inter-local agreement and /or for termination of the membership of one or more counties in the agreement.

E. Process and Timeframes for the Formation of Regions

The Regional Workgroup had considerable discussion of the process for formation of regions and the elapsed time necessary to form regions that can be successful, have the buy-in of county supervisors and have support of consumers, families and other stakeholders. The workgroup also recognized that there will need to be a transition period of at least a year after formation of regions during which they will draft county management plans, create provider networks, formalize the designation of access points and targeted case management, and put into place all necessary information technology and business systems to (a) be successful as regions; and (b) meet DHS criteria for performance contracting with regions (see Section H below).

SF 525 specifies a target date of July 1, 2013 for "full implementation" of the redesign plan. To the extent regions are critical to the implementation of the overall redesign plan, they will have to be ready

3 It is assumed that the 28E agreement will form the basis and framework for by-laws to be created by each regional board. These by-laws will spell out in greater detail the structure and operations of the governing board and the formally established advisory groups (consumers and families; providers).

to begin operations and transition activities on the same date. However, it should be noted that some members of the Workgroup advocated for a longer process, with implementation to begin on or about July 1, 2014. The basis for extending the timeframe was a concern that county supervisors will need more time to understand the redesign process and to make informed decisions about the best way to collaborate with other counties in the formation of regions. A countervailing position among Workgroup members was that there is momentum for change now, and that delay could result in dissonance about the redesign objectives and process.

There was considerable consensus among Workgroup members related to the process for formation of regions. The discussion focused on attaining a reasonable balance between the benefit of "organic," voluntary formation of regions versus the recognition that DHS would have to have some authority to act if such voluntary regions were not formed or if one or more counties were to be left out of contiguous regional groupings.

The following is a brief summary of the points of consensus reached by the Workgroup:

- There was consensus that the basic standards and criteria for regions should be established by statute as opposed to by regulation.
- In this context, there was consensus that the population ranges for regions (200,000 to 700,000) should be stated as "targets" as opposed to absolutes, to allow for some discretion on the part of DHS to approve/contract with regions not exactly meeting the population criteria.
- There was consensus that the statute should give DHS authority to:
  - Assign or re-assign counties to regions if they have not joined a region by a date certain as established by the legislature or if a region is re-structuring membership for some reason.
  - Intervene to assure continuity of services and payment for providers if a region is "breaking up" or fails to meet performance standards.
- There was agreement that if a region is ready to go at any time after enactment of the legislation,[4] it could start functioning as a region and could be eligible to receive TA from DHS.
- There was no consensus on the criteria for "when a Region is ready to start". Criteria discussed included:
  - Identification of the member counties.
  - Meeting all regionalization criteria to be included in the statute.
  - Approval by County boards of commissioners of "letters of intent" to form a region.
  - Approval of a 28E agreement by each of the participating counties (Boards of Supervisors, it is assumed).
  - Draft of the first regional management and strategic plan (it was noted that this would be a "transition plan," not a complete management and strategic plan).

4 Assumed to be April 2012 or so.

These latter criteria for "readiness to begin" could be set by DHS and guidelines and/or as performance contract criteria. Given that early-adopting regions will be eligible for technical assistance from DHS, it is likely that such criteria will emphasize the commitment to form a viable region, rather than full operational readiness.

The Workgroup held further discussions of these issues at the October 25th meeting. It was decided to conceive of the establishment of regions as having two stages: "formation" and "implementation".

For the "formation" phase, the Workgroup recommended the following criteria:

- The counties to comprise a region have been identified.
- The County Supervisors have signified their intent to join a certain region through a written letter of intent.
- The regional formation proposed by the participating counties meets all the statutory criteria included in the enabling statute enacted (hopefully) by next spring.
- DHS agrees in writing to the participating County Boards of Supervisors that the counties forming the region are in compliance with statutory requirements.

Once the following criteria have been met, a regional group can begin receiving technical assistance and support from DHS. There is no necessity for regions to wait until the end of the process to indicate their intent to form a region and to receive DHS approval.

For the "implementation" phase, the Workgroup recommended that the following criteria constitute a "readiness review" for a region to begin full operations:

- A 28E agreement has been signed by the parties.
- The County Supervisors in each participating county have voted to approve the 28E agreement.
- The County Supervisors of designees to constitute the governing board have been appointed/identified.
- An executive has been identified/engaged for the regional group.
- A "transition" regional management/strategic plan is been drafted which identifies the steps to be taken to (a) designate access points; (b) designate TCM; (c) identify the provider network; (d) define the service access/service authorization process; (e) identify the IT/data management capacity to be employed to support regional functions; and (f) establish business functions, funds accounting, etc.
- DHS has approved the 28ER agreement and the initial draft "transition" plan.

A. Timeline for regional formation and implementation

As noted in earlier discussions, SF 525 specifies an implementation date of July 1, 2013.

The Workgroup recommends a time line based on the criteria listed above, as described in Table Two below:

Table Two: Timeframe for Regional Formation and Implementation

Date	Activity	Comments
April 2012 or thereabouts	Enactment of the enabling statute for the MHDD system redesign.	Criteria for regions, requirements for 28E agreements, etc. are expected to be included in this statute.
January 2012 through June 30, 2013	Regions voluntarily forming and meeting statutory criteria will be eligible for TA from DHS.	
January 2012 through 2013	DHS will work with counties and nascent regions to assist with regional formation. By April. 2012, if regions have not formed, or if there are "orphan" counties, DHS may step in to negotiate and/or assign membership.	
July 1, 2013	All regions meet the "formation" criteria listed above.	Between 7/1/13 and 6/30/13 the regions could potentially be operating under "one plan" and a unified financial management system, but they could also be operating as "virtual regions as they work to meet the "implementation" criteria by 7/1/14.
July 1, 2014	All regions meet the "implementation" criteria listed above.	

F. Functions of Regions

Table Three below summarizes the planned functions of regions as determined by the Regional Workgroup.

Table Three: Functions of Regions: Consensus Recommendations

Function	Yes	No	Comments
Regional Management and Strategic Planning	X		
Designation of Access Points	X		

Function	Yes	No	Comments
Designation of TCM	X		Modalities and providers of TCM to be defined by DHS, not the regions
Designation of service management for non-Medicaid people/services	X		
Plan for Core Services	X		
Plan for Systems of Care	X		
Assure effective crisis prevention, response and resolution	X		
Provider network formation and management	X		
Provider reimbursement approaches for non fee-for-service modalities and for non-traditional systems of care providers	X		Must use standard state uniform cost report as applicable
Provider certification	X	X	Not for state licensed or certified providers, but yes for non-traditional and non-licensed providers
Grievances	X		Regional discretion within guidelines for the grievance process
Appeals	X		Must be consistent statewide
Quality Management/Quality Improvement	X		
Assurance of payment of providers	X		Invoice adjudication and direct provider payments do not necessarily have to be done within each region. However, each region needs to be accountable for timely and accurate provider payments.
Funds accounting	X		
Financial forecasting	X		

Function	Yes	No	Comments
Data collection and reporting	X		As with provider payments, certain data collection and reporting functions could be shared among regions and/or centralized, as long as each region can use its data for provider accountability, consumer access and outcomes, funds accounting, etc.
Interagency and multi-systems collaboration and care coordination	X		

The functions outlined above were determined by the Workgroup to be the essential core functions necessary for a region to be held accountable and to meet performance standards. It will be noted that the functions listed above do not rise to the level of the regions becoming "managed care companies" or functioning in a full risk environment. However, the Workgroup understood that regions will be operating with fixed global budgets,[5] and thus will need to have financial management and analytic capacities to manage effectively within their fixed budgets.

The Workgroup discussed some additional potential functions of Regions that could be considered for the future. These include:

- Management of the provision of Interim Assistance Reimbursement;
- Have regions hire and manage the Mental Health Advocates;[6]
- Make Regional designated TCM entities access points to apply for the Home and Community Based Waiver programs;[7]
- Give regions authority to contract with MHIs and Resource Centers for beds;
- Give Regions the ability to manage some detoxification services, shelter care and the Toledo Center; and
- Assign Money Follows the Person case managers to each region.

The Workgroup agreed that Regional management of what has traditionally been a county function, such as Interim Assistance, would logically fit within the responsibilities of the regions. With regard to the other suggested functions, the Workgroup recommended that these be initially considered as issues

5 Comprised of county levy funds, state allocated funds, and any other recurring sources of funding.

6 Note: the Judicial Workgroup has recommended that the Mental Health Advocates become a state function.

7 The ID-DD workgroup has recommended that TCM entities assist with HCBS waiver applications, etc., but has noted that only DHS/IME can actually approve eligibility for the waivers.

for coordination and inter-systems collaboration. For example, access to Home and Community Based waivers will also be facilitated through the Aging and Disability Resource Centers being established by the department on Aging. The workgroup did not recommend further action on these potential functions at this time.

The Workgroup also discussed the degree to which regions should have discretion with regard to the implementation of certain regional functions. Table Four below summarizes the consensus recommendation of the Workgroup with regard to regional discretion.

Table Four: Regional Discretion to Implement Essential regional Functions

Function	Regional discretion within state standards	No discretion – must be consistent statewide	Comments
Regional Planning	X		Must follow DHS guidelines/topic areas
Designation of Access Points	X		Must be able to meet access standards established by DHS
Designation of TCM	X		Only can designate DHS/IME approved providers
Plan for Core Services		X	Core services will be defined by DHS and all regions will have to assure that core services are consistently and equitably available within each region
Plan for Systems of Care[8]	X		
Assure effective crisis prevention, response and resolution	X		
Provider network formation and	X		Must abide by state licensure/certification

8 In this context systems of care includes non-traditional services and providers, including employment, housing assistance, informal care-giving, self direction, and other activities that are essential to maintain people in systems of care but are not defined as core services.

Function	Regional discretion within state standards	No discretion – must be consistent statewide	Comments
management			process and decisions
Provider reimbursement approaches for non-fee for services or non-traditional systems of acre providers	X		Must use standard state uniform cost report
Provider certification	X	X	Yes for for non-traditional, non Medicaid services and providers that comprise systems of care; but no for providers licensed/certified by the state
Grievances	X		
Appeals		X	
Quality Management/Quality Improvement	X		
Payment of providers		X	Regional accountability but function can be shared/contracted out
Funds accounting		X	Regional accountability but function can be shared/contracted out
Financial forecasting	X		
Data collection and reporting		X	
Interagency and multi-system collaboration and care coordination	X		

G. Regional Management and Strategic Plans

The Workgroup recognized that a key function of the regions will be to develop regional management and strategic plans. The Workgroup reviewed current DHS standards for county management and strategic plans, and found these to meet most of what should be included in the Regional Plans. The Workgroup recommends that the contents of regional management and strategic plans be established by DHS rulemaking, and that the statute provide DHS the authority for such rule making but spell out the contents of the plans.

Consensus was reached on the following outline for the required regional management and strategic plans:

1. The Regional Management Plan

- Basic information on the geographic area covered by the region
    - Communities served
    - Socio-demographics of the citizens
    - Locations of major service centers, hospitals, etc.
    - Identification of the central administrative entity for the region (the single point of accountability
    - Description of the governance board of the regional administrative entity
- Description of the roles of consumers and families (and other stakeholders if applicable) in the design, operations and evaluation of regional functions
- Specification of people to be served
    - IDD (Adults and Children/Youth)
        - Clinical/level of care criteria for service access
    - MH (Adults and Children/Youth)
        - Clinical/level of care criteria for service access
    - Children's Systems of Care
    - Other disability populations (e.g., people with BI) as provided by the Legislature/DHS
    - Financial eligibility requirements for each service population – sliding scale (if applicable)
- Specification of services to be provided
    - Core services - Transition plan during first year of operations
    - System of Care services (in addition to core services which may be included as resources on a case-by-case basis for people in systems of care)
- Specification of clinical/level of care criteria for accessing each core service and systems of care for each sub-component of the service population
- Customer relations
    - Information dissemination
    - Information and referral
    - Outreach and engagement
    - Process for consumer and family grievances (not appeals – these are included under service authorizations)

- Designation of access points
    - Locations, contact information
- Description of how services are accessed
    - Roles of access points
    - Roles of the regional administration with regard to service authorization and re-authorization (previously considered to be CPC functions)
    - Description of the service application process
    - Description of methods to assure consumers informed choice of services and providers
    - Description of how, when, why, and by whom clinical assessments are conducted
    - Description of how, when, for whom, and by whom a person centered plan is developed
    - Process and criteria for issuing notices of decision (or service authorization process) and continued stay authorization
    - Plan and protocols for coordination with Medicaid managed behavioral health care and Medicaid Home and Community Based Services
    - Process for appeals of service authorizations/decisions
    - Description of how conflict of interest and self-dealing is avoided in the service access, service planning and service authorization processes (note: this is not just an issue for TCM)
- Designation of targeted case management
    - Specify source(s) of TCM for each sub-population
    - Identify specific roles and functions of TCMs with regard to person centered planning, care coordination and service authorization for each sub-population
    - Identify how TCM-like service planning, coordination, linkage and monitoring functions may be carried out by other service modalities (e.g., Assertive Community Treatment teams, community support teams, children's Specialty Health Homes, etc.)
    - Define the responsibilities of TCM with regard to clinical homes and multi system care coordination
    - Define the responsibilities of TCM with regard to care coordination between Medicaid and non-Medicaid services
- Designation of service management for non-Medicaid eligible consumers
- Specification of the provider network
    - Name the providers of each core service and systems of care for each sub-population
    - Specify the methods and criteria for selecting providers for the network
        - Use of state certification/credentialing processes and criteria
        - Use of national accreditation status
        - Use of statewide uniform cost reports and rate setting mechanisms
        - Provider data submission requirements
    - Assurance of provider network sufficiency
        - Choice of provider for core services
        - Cultural linguistic competence
        - Geographic access
    - Methods of provider billing and reimbursement

- Specification of the regional crisis prevention, response and resolution system
    - Crisis planning with consumers, families and providers
    - Early warning systems
    - 24/7/365 call center
    - Mobile services
    - Crisis respite capacity
    - Response to crises in ED's, jails, shelters, etc.
    - Methods for reducing arrests and incarcerations
    - Process for acute psychiatric admission if necessary
    - Specialty crisis capacities for IDD, children and youth, etc.
    - Relationships with first responders, hospital emergency departments, magistrates, advocates, etc.
- Outcome and Performance measurement
    - State domains and indicators: annual performance targets (benchmarks)
    - Regional performance objectives and indicators and benchmarks
    - Use of performance data for management of the quality and effectiveness of the region
- Regional business functions
    - Information technology and data reporting
    - Service authorization and expenditure tracking
    - Provider contracting and performance monitoring
    - Funds accounting and financial forecasting
- Description of inter-organizational relationships and functions within the region
    - County officials
    - Justice system
        - Judges/magistrates/advocates
        - Sheriff/police
        - Jail
        - Juvenile justice
        - Probation and parole
    - Education
        - Specific transition planning relationships, points of contact, etc.
    - Housing
    - Employment
    - Substance abuse services
    - Health Care
        - First responders
        - Emergency departments
        - Health centers/FQHCs
    - Description of interagency care coordination process where applicable
- Quality Management/Quality Improvement Plan (summary)[9]
    - Quality issues to be addressed and objectives for improvement
    - Data aggregation[10] and analysis plan related to each issue

[9] Each region is likely to have a more detailed annual QM/QI plan.

[10] Primarily from existing and regularly collected data sources.

- Process to be used and resources to be committed to each quality objective
- Time frame for completion

2. The Regional Strategic Plan

Note: for the first year(s) of regional operation, the strategic plan will focus on transition issues and activities such as meeting core services requirements, establishing regional care coordination functions, developing regional business systems and capacities, etc.

- Needs assessment
  - How many of each defined need population (IDD, MH, Children and Youth, etc.) are estimated to need the types of services offered under the aegis of the region?
  - Description of special needs for services (e.g., health disparities, cultural or linguistic competence, etc.).
- Gaps analysis
  - What are the numeric gaps between the number of people served in each sub group and the estimated need for services for each sub-group?
  - What required or desired services are currently not as accessible or specialized as needed in the region (e.g., there is insufficient IDD supported employment capacity; there is insufficient child crisis response capacity; there are insufficient bi-lingual MH clinicians)?
  - What operational functions or systems need improvement to be more efficient and/or to provide more responsive services to constituents (e.g., improved service linkage and consumer choice; improved grievance and appeals process; more accurate data reporting)?
- Strategic objectives and action steps
  - What measurable action steps will be taken over a three year period to address identified needs and fill identified gaps in the service system?
  - What steps will be taken to improve the quality and effectiveness of the service delivery system?
  - What steps will be taken to assist providers and their direct service staff to learn new skill and provide better practice services?
- Indicators of progress towards and attainment of strategic plan objectives and action steps
  - Milestones for strategic action steps.
  - Indicators of outcomes for consumers/families and communities. (What will have actually changed for people and how will it improve their lives?)[11]
  - Specification of incentives/rewards for attainment of or contribution to strategic plan objectives.
- Consumer and family Involvement in Plan development
- Other stakeholder involvement on strategic plan development

[11] These most likely will be drawn from the standard set of outcome and performance measures adopted on a statewide basis.

H. Performance Indicators for Regions

A key feature of SF 525 is the expectation that performance based contracts will be established between the state (DHS) and the regional entities. The Regional Workgroup recognized that for performance contracts to be established, there must be a clear and objective set of performance indicators to be applied on a consistent and transparent basis to assess and profile regional attainment of performance standards. The Workgroup did not attempt to define specific performance indicators or benchmarks, or to identify the sources of data for these indicators. These will be developed later in the implementation process. However, the Workgroup did identify the major domains for regional performance measurement. These are summarized in Table Five below.

Table Five: Performance Domains and Examples of Performance Indicators for Regions

Performance Domain	Examples from other States[12]	Comments
Attainment of consumer and family outcomes	Employment; community living; children in families; children successful in school; quality of life	State-defined outcome domains and indicators reported and profiled at the regional level
Attainment of system performance outcomes	Reduced inpatient bed day utilization; reduced congregate care bed day utilization; family stability & re-unification; penetration rates; children served near their family	State-defined system performance measures reported and profiled at the regional level
Attainment of defined quality standards	Accreditation; credentialing; appeal and grievance frequencies and resolutions; critical incidents; workforce development; consumer/family satisfaction	Relate to CMS quality framework for waiver services
Ease of access to core services	Elapsed time from intake to first service; timely service connections following facility discharge; no gap in services for transition age youth	
Effective and consistent operations of TCM	Attainment of consumer outcomes; consumer choice and satisfaction with case manager	Must be monitored by DHS/IME, too

12 The other Workgroups are developing recommended outcome and performance measures for Iowa. These are included just to provide examples of what types of performance indicators are typically included in these domains.

Performance Domain	Examples from other States[12]	Comments
Provider network sufficiency	Adequate provider choice; cultural and linguistic competence; attainment of consumer outcomes	
Successful crisis prevention and diversion	Reduced crisis presentations at acute care sites; reduced inpatient hospitalization; reduced arrests; maintenance of community living (family and/or independent)	
Evidence of continuous quality improvement of all regional functions, including provider quality and effectiveness and workforce development	QM/QI reports documenting progress and results of QM/QI initiatives	
Timely and accurate payment of providers[13]	90 percent of clean claims paid within 30 days of submission; provision of accurate explanations of benefits to consumers (if requested) and providers	
Accurate funds management	Clean annual audit; less than 5% variation form annual budget; attainment of administrative cost limitations	
Compliance with applicable state regulations and the performance contract between the state and the regions	Results of state monitoring and reporting of compliance with contract terms	

13 Including this domain does not assume that each region will physically adjudicate and pay claims – it only means that regions will be responsible to see that claims are paid in a timely manner and to correct problems if they exist.

Performance Domain	Examples from other States[12]	Comments
Timely and effective resolution of grievances and appeals	Meeting all timelines for appeals and grievances; low frequency of reversal of service authorization decisions on appeal; documented use of grievance and appeal data in QM/QI activities	

The Workgroup emphasized that while each region should be held accountable for and profiled on a standard set of performance indicators, each region should also establish "aspirational" goals and attendant performance measures related to their own strategic and QM/QI plans.

I. Residency

The Workgroup considered the definition and application of "residency" as it applies to regional administration of funds. The objective of the discussion was to assure that the concept of residency would not become another form of "county of legal settlement". The Workgroup agreed that the definition of residency as adopted by the MHDD Commission should be implemented. This definition is included as Appendix D of this report. The Workgroup also recommends that core services operated under the aegis of regions be considered as statewide services, and that regional residency not be used as a criterion for denial of service if other eligibility and clinical criteria are met. The Workgroup recognizes that there may occasionally be disputes about legal responsibility to pay for a person's services, and that there is already a resolution mechanisms available in statute which can be triggered when necessary. The Workgroup agrees that services should be continued pending the outcome of that review mechanism. Finally, the Workgroup recognized that uniform data about service access and utilization will be more readily available under the reformed system, and therefore, cross regional migrations for service access can be tracked and documented. If a disproportionate impact can be documented from the data, DHS could use state funds to remedy the imbalance.

J. Conclusion

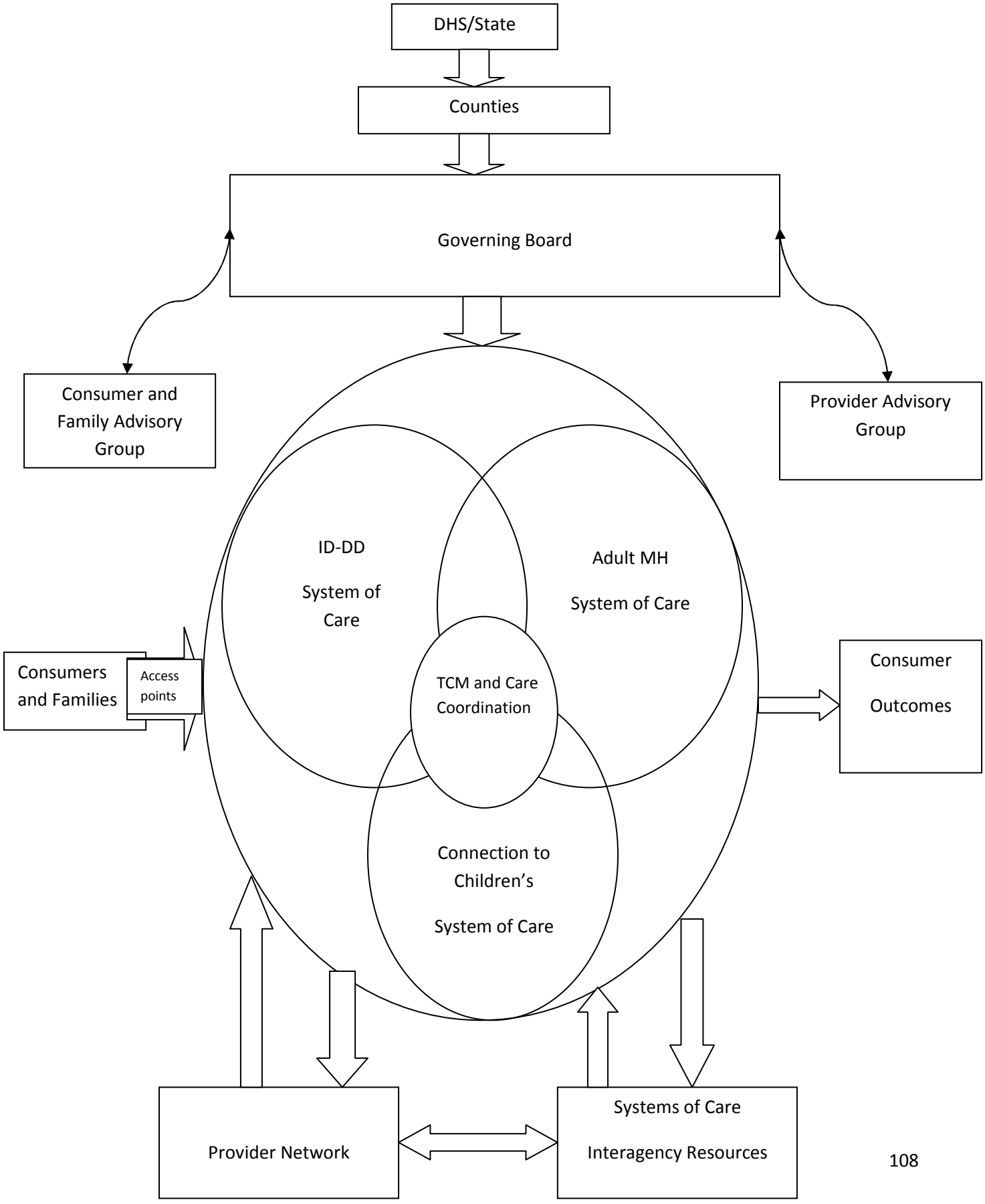
Taken all together, the recommendations of the regional Workgroup create a vision for a regional structure that incorporates the following features:

- Establishment of a single point of clinical and financial accountability for non-Medicaid services for all citizens of Iowa.
- Establishment of a regional entity that can build on the best elements of current county systems while at the same time improving access to core services and attaining consistency of service access and delivery.

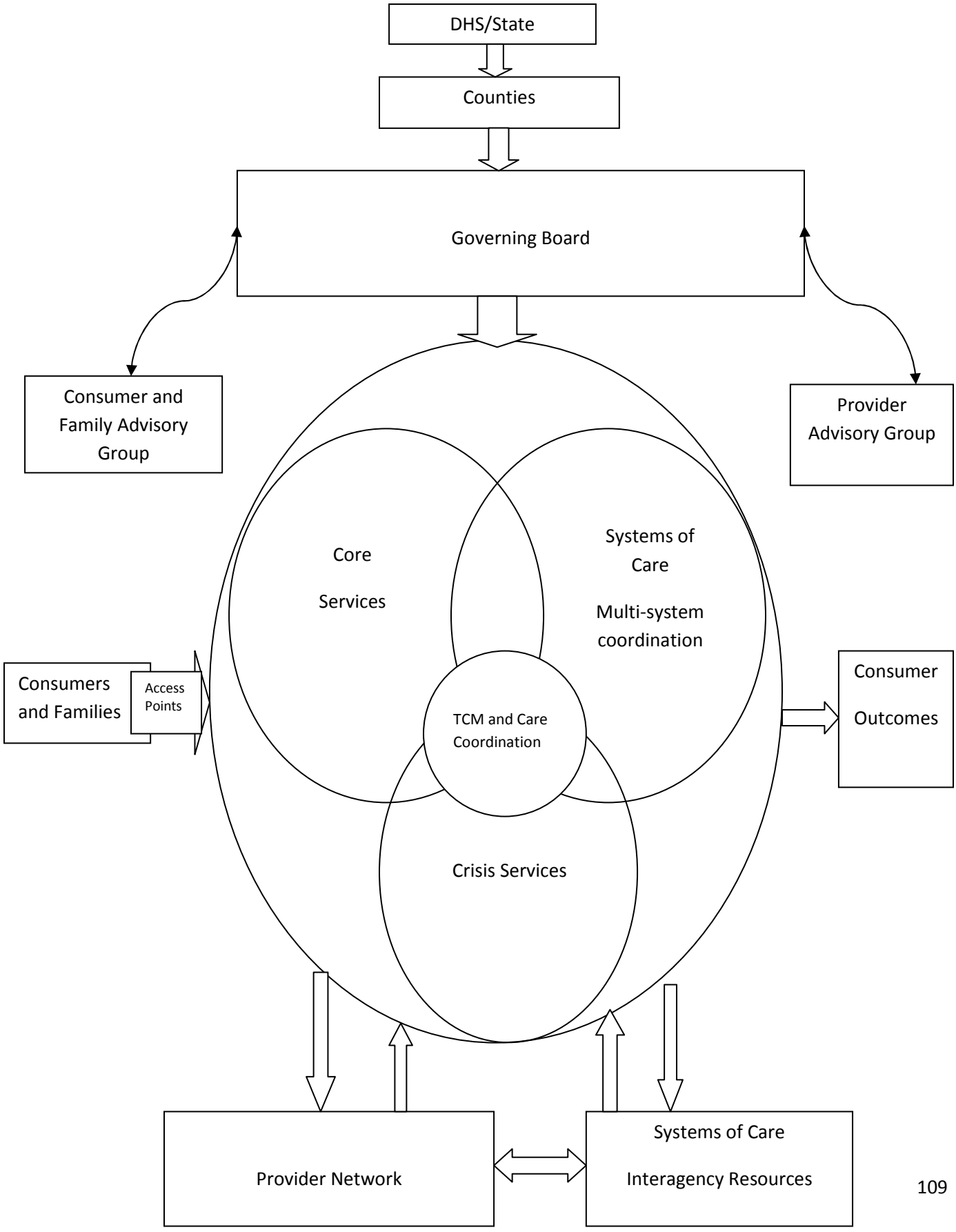
- Maintenance of the strength of local interagency and multi-systems arrangements and relationships while also attaining some economies of scale.
- Creation of regional entities that can function as the unified managers of systems of care and different service modalities for consumers with different disabilities and service needs and choices, while at the same time fostering integration, coordination and reduced duplication between these various systems of care and service modalities.

The two charts on the following pages display these integrative functions of regions: first for the different disability populations, and second for core and system of care service modalities. The charts reflect the vision communicated in the above recommendations of the regions as the local "face" of MH, ID-DD and children/youth services. They also reflect the regions' responsibilities to facilitate access to and coordination of care across multiple systems.

System of Care Coordination at the Regional Level



Service Integration and Coordination at the Regional Level



Appendix D: Recommended Definition of Residency

The new definition of residency as approved by the MHDD Commission is quoted below:

"*County of residence" means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good faith intention of living permanently or for an indefinite period. The "county where a person is living" does not mean the county where a person is present for the purpose of receiving services in a hospital, a correctional facility, a halfway house for community corrections or substance abuse treatment, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility, nor for the purpose of attending a college or university. For an adult who is an Iowa resident but falls within the exclusion for "county where a person is living" as described in this rule, the county where the adult is physically present and receiving services shall be the county of residence. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps.*