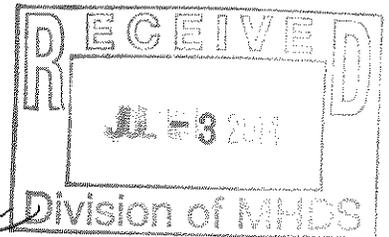


To: Rick Shults, Administrator, Division of Mental Health and Disability Services
Iowa Department of Human Services
From: County Social Services Board of Directors
Re: Draft Transition Plan
Date: June 25, 2014



The following is the transition plan for County Social Services to meet the requirements set forth in legislation to become a fully operational regional service system:

331.389(4)e On or before June 30, 2014, unless exempted pursuant to subsection 1, all counties shall be in compliance with all of the following mental health and disability services region implementation criteria:

(1) The board of supervisors of each county participating in the region has voted to approve a chapter 28E agreement.

(2) The duly authorized representatives of all the counties participating in the region have signed the chapter 28E agreement that is in compliance with section 331.390.

CSS has completed the 28 agreement and will submit the signed agreement to the Secretary of State and a representative of DHS MHD Division prior to June 30, 2014.

(3) The county board of supervisors' or supervisors' designee members and other members of the region's governing board has been appointed in accordance with section 331.390.

CSS has a seated board member from each member county's Board of Supervisors, a designated provider representative recommended by the provider's advisory committee and a designated individual receiving services designated by the consumer's advisory committee.

(4) Executive staff for the region's regional administrator have been identified or engaged.

CSS has appointed a CEO and other executive staff to provide regional administration.

(5) An initial draft of a regional service management transition plan has been developed which identifies the steps to be taken by the region to do all of the following:

(a) Designate local access points for the disability services administered by the region.

CSS has designated the CSS Offices as the access points for services with an initiative to expand and incorporate LifeLong Links in collaboration with our AAA partners across the region and state. This affords a fully staffed call center and no wrong door approach to aging and disability services as envisioned by the Affordable Care Act.

(b) Designate the region's targeted case manager providers funded by the medical assistance program.

CSS has established standards for performance of all regional TCM providers including a common EMR platform to fully integrate Medicaid and non-Medicaid funded services. TCM providers are formally designated by the execution of a network provider agreement.

(c) Identify the service provider network for the region.

CSS has executed provider agreements with all providers that are hosted by the region. Terms on the agreements and rates are loaded into CSN to be shared across the state MHD system.

(d) Define the service access and service authorization process to be utilized for the region.

Revisions have been made as directed by the department and are contained in the revised 104 Funding Policy and Procedure. See attached.

(e) Identify the information technology and data management capacity to be employed to support regional functions.

CSS has an extensive IT and data management capacity that has been developed over the past five years. We have a shared email exchange server. We have centralized server capability and complex collaboration with all of our CSS member counties. We have engaged web based technology to make work process more efficient and to improve access to stakeholder meetings. We have completed our first external HIPPA Security and Privacy audit and continue to roll out secure email.

(f) Establish business functions, funds accounting procedures, and other administrative processes.

CSS has a well-organized business process that uses a combined account managed by a fiscal agent to provide efficient and effective accounting procedures that are audited by the State Auditor's Office. The specifics of the process are outlined in the Finance Policy recently submitted as part of the MHD Service Plan.

(g) Comply with data reporting and other information technology requirements identified by the department.

CSS will comply with all data reporting and other information technology requirements of the department including those referenced in Iowa Code 225C.6A. Please see attached 114 Data Reporting Policy and Procedure.

(6) The department has approved the region's chapter 28E agreement and the initial draft of the regional management transition plan.

CSS will have a fully executed 28E agreement for review by the department on or before June 26, 2014. The 28E agreement contains the identified recommendations of the department from the previous agreement. This document will be submitted along with 28E agreement as CSS's initial draft of the regional management transition plan.

Policy

CSS will develop a funding process that is welcoming and responsive to individuals in need while rigorously applying the proper criteria for eligibility and funding determinations.

County Social Services will use resources to:

- fill the gaps of the Medicaid health-related support service system;
- bridge individuals into the appropriate Medicaid health-related support services while pending enrollment;
- provide support while pending a Social Security disability determination; or
- provide rehabilitative and support services that help non-Medicaid individuals to recover or maintain their ability to live in the community and prevent or reduce Medicaid long term support and service costs.

Procedure

Access

Individuals will access the CSS MHD Plan as set forth in the Service Plans.

Enrollment (Level 1)

All callers and visitors are eligible for information and assistance, public education with no application.

Individuals requesting Level 1 services must provide the Minimum Data Set (441-25.41) in some form. CSS Coordinator of Disability Services may accept self-reported mental health diagnosis for Level 1 assistance. Service Coordinators will enter the data from Level 1 or an application into CSN and enter a "pending" application eligibility decision under the "Application Decision" tab. Then send an email to the Coordinator of Disability Services to review client number XXXXXX.

Enrollment (Level 2)

Only County Social Services Offices can make an eligibility determination for Level 2 services. To apply an individual must complete an application or Level 1 and Level 2 assessment (Appendix K Level 2) and sign the necessary releases of information to obtain primary source verification of the existence of a mental illness, intellectual disabilities, developmental disability or brain injury. A Service Coordinator, Care Coordinator, Targeted Case Manager or Options Counselor (herein after are included in any reference to a Service Coordinator) will schedule an intake interview within 10 working days of receiving an application or Level 1 referral to assess service needs and to complete the following enrollment process:

Intake Process

Here is the process for completing enrollment for Level 2 . Complete the following checklist:

1. Review application/Level 1 to see that it is complete.
 - a. The individual must answer each question by responding with 0 or NA when they have nothing to report or the question does not apply to them.
 - b. County Social Services has designated the standard CSN application, one page CSS application or Level 1 form. County Social Services will accept any other application approved by another MHD region.
 - c. Any barriers to the completion of the application i.e. language, sight, intellectual disability must be facilitated by the Service Coordinator.
 - d. Applications will be available at all CSS Offices, on the CSN site, CSS website, LifeLong Links, designated Mental Health Centers and other access points.
2. The Service Coordinator may initiate a funding request for services if there is a presumption of eligibility and the welfare of the individual is best served by not waiting to complete the intake process.
3. Request third party verification of information provided on application if needed.
 - a. Establish that the individual is a legal resident of the United States by
 - i. verifying SSI, SSDI, SS, or Medicaid Eligibility **or**
 - ii. photocopy a valid driver's license, state identification card, Social Security card or birth certificate.
 - b. Income & Resources
 - i. Verify Medicaid Eligibility (Medicaid eligibility assumes they meet the income and resource guidelines for this plan. MEPSD eligible are do not meet resource guidelines) **or**
 - ii. Complete copies of all savings/checking account statements for the last three months and proof of any income and resources recorded on the application. Service Coordinator may waive this requirement if deemed a hardship. The individual is reminded that a misstatement on a government application is a serious crime and may jeopardize eligibility for future benefits.
 - c. Legal Documents
 - i. Copy of Power of Attorney; Conservator or Guardianship documents; Civil Commitment documents; criminal history and correctional status (parole, probation, incarceration).
4. Complete a Level 2 Assessment (Appendix L).
5. Complete a brief service and social history.
6. Complete a Rapid Plan (Appendix M)
7. Schedule an intake for a standardized assessment. (must be completed within 90 days)

8. Request releases of information to verify the existence of a covered disability and to coordinate referrals.

Primary Diagnosis	Documentation Needed	Provider
Mental Illness	Most recent Psychiatric Evaluation	Psychiatrist, MD, DO, LSIW, ARNP(psych), PA
Intellectual Disability	Most recent Psychological Testing and must include testing prior to age 18	Psychologist
Developmental Disability	DHS Checklist for Verification of Developmental Disability Diagnosis Form 470-3824	Psychiatrist, MD, DO, LSIW, ARNP, LMSW, PA
Brain Injury	Most recent medical exam with covered brain injury diagnosis, cause and date of brain injury.	Psychiatrist, MD, DO, LSIW, ARNP, Psychologist

9. Complete a Social Security Interim Assistance Agreement if the individual does not have a Social Security Disability Determination. This form must be signed and dated by the appropriate Coordinator of Disability Services and submitted to SSA.
10. Provide information on the plan, services available and other community resource.
- a. Offer a copy of :
 - i. Relevant Service Plan
 - ii. County Social Services Privacy Policy
 - iii. Local Resource List (specific materials for specific referrals)
11. Assess the ability of the individual to independently access resources and recommend the most appropriate level of service coordination e.g. Targeted Case Management, Service Coordinator, Outreach Worker, Health Home, Community Support Program Worker, Vocational Service Coordinator, family, provider or self. Inform the individual of their right to choose their service provider.
12. When the Service Coordinator refers an individual to another agency, he/she must follow up within 2-5 days and again in 30 days is encouraged to ensure that the individual connected with the appropriate resources.
13. The Service Coordinator will enter the individual's information into the MIS system and prepare a CCISC Presenting Report (Appendix O) to the County Social Services Level 2 Review.

Level 2 Review

The Service Coordinator will present their client for Level 2 Review. The Service Coordinator should use the CCISC Presenting Form (Appendix O). The review will be with a Coordinator of Disability Services and anyone else that may have expertise in an area of need for the individual

(i.e. Medical Director, PBSI Coordinator, Care Coordinator, Public Health, and IHH). *The client should be informed but not included in this process.* The Coordinator of Disability Services will:

1. Determine primary service plan
2. Review medical necessity
3. Determine level of care (*The level of care determination does not fix or cap services entitled to an individual.*)
4. Assign care coordination (Service Coordination, TCM, Options, HH, etc.)
5. Identify smart next-steps of progress that the person and team can work on together.
6. Request a Notice of Decision from the CEO.

Eligibility Determination

Based on the outcome of the Level 2 Review the Funding Coordinator will generate a Notice of Decision for the CEO to sign within five days of the completed enrollment process. If the standardized assessment has not been completed before the initial Notice of Decision, then the CEO will send a revised Notice of Decision within five days after receiving the standardized assessment only if it requires a change in the original decision.

If eligibility is approved, reimbursement will go back to the first day for the month of application or the first day of residence in the CSS region. **The CEO may approve exceptions as necessary to ensure the health and safety of applicants.**

The Notice of Decision will be mailed to the individual at the best address available. It will include the following:

1. Notice of Decision/Appeal Process
2. Assigned care coordinator contact information
3. Privacy Notice
4. Copy of the approved Service Plan

Service Coordination

All Level 2 services and supports require that a Service Coordinator request funding in writing (Provider on the Fly) or online through CSN to a Funding Coordinator. Funding requests must include the service requested, units of service needed, cost per unit, begin date, end date and, if the request is significantly different from the previous request, an explanation for the change in level/site of care.

Service Coordinators will conduct ongoing reviews of service funding to ensure most appropriate level of care.

It is important that the Service Coordinator advocate for their clients. If the individual is not satisfied with the funding determination, the Service Coordinator should assist the individual with appealing the funding decision or requesting an exception to policy.

Urgent Funding Requests

If it is an urgent request for services the Service Coordinator will send an email and or phone the Funding Coordination Team so that the first available Funding Coordinator can review and approve the request within **one hour**. **Urgent need means:**

1. The request supports discharge from an acute setting (hospital, ER, jail, Crisis Center)
2. The request supports an individual in crisis.
3. The request supports the avoidance of eminent homelessness, discharge from needed supports or services, and/or incarceration.

Service Monitoring

Service Coordinators will regularly review services authorized, services used and an individual's current needs to ensure only medically necessary services continue. Individual service plans will be reviewed annually at a minimum.

Service plans may be staffed and reviewed at any time.

Funding

CSS will designate a lead and at least two additional Funding Coordinators to coordinate all CSS funding requests to ensure prompt, consistent and accurate funding decisions. Funding Coordinators must have a four year degree and a minimum of two years of direct experience in managed care. (Personnel 503 Funding Coordinator)

A Funding Coordinator will have 5 working days from receipt of a request to make a decision. If it is determined to be urgent, the team will have one hour to respond or any Coordinator of Disability Services or the CEO may review and approve.

The following are guidelines for the review of funding requests:

1. Individual must meet the criteria for enrollment into the respective CSS Services Plan and have an active or pending eligibility decision (pending means that an application has been entered into CSN waiting approval).
2. Be a resident.
3. Service requested must be covered in the CSS Service Plan (see #7 below for exceptions).
4. Service provider must have a current contract and established rates with County Social Services or another county/regional entity or have an executed Provider on the Fly Form.
5. An initial request should have a service plan attached to the record and identify the service need.
6. Service requested should be within the established level of care for the individual. Funding Coordinator may request further assessment if the request does not appear consistent with the record.
7. Exceptions to Policy by CEO or designee are allowed for the health and safety of the individual. ETPs must be documented and sent to the lead Funding Coordinator to place on file. They will then be reviewed at the next County Social Services Board Meeting.

Once funding is approved the Service Coordinator will be responsible for communicating the funding approval to the provider and copy the individual if requested. **If the request was denied the individual must be given a copy and include the appeal process. Service Coordinator may assist individuals in understanding their right to appeal and the process to exercise their right.**

The MIS system will track and record all funding decisions. County Social Services will not store paper records of funding decisions.

Audit: Under the fiscal agency contract, we may request regular performance audits of our program that is similar to the State Auditor's protocol or conduct random internal audits.

Exception to Policy

Exception to Policy may be considered in cases when a consumer is significantly affected by the regional eligibility policy. To request an Exception to Policy, the consumer or the consumer's Service Coordinator shall submit the following information after receiving a denial from the Funding Coordinator:

1. Consumer's name
2. Current services the consumer is receiving
3. The policy for which the exception is being requested
4. Reason why the exception should be granted

The Funding Coordinator will present to the CEO to review the exception and a response will be given to the individual and, when appropriate, the Service Coordinator within 10 working days. Decisions on requests shall be submitted to the CSS Board at their next regular meeting and used in the annual report to identify future changes in policy.

Exclusions

County Social Services will not reimburse any Level 2 service without prior approval.

Ongoing supports may be back dated by the Service Coordinator up to 60 days beyond expiration date. Expirations beyond this period will be denied and sent to the CEO for review. The CEO may present the denial for Board review.

County Social Services will not assume responsibility for reimbursement of any unpaid, unauthorized, or ineligible service under the Medicaid Program.

County Social Services will not be responsible for any obligation of a provider to repay the Medicaid Program.

County Social Services will be the payer of last resort. Providers, Case Managers, and individuals will pursue other potential funding sources before requesting County Social Services funding.

County Social Services will honor the Iowa Plan's determination of medical necessity and not fund services beyond their decertification for a similar service.

Individuals eligible for Medicaid programs will only be funded with discretionary funds while waiting for Medicaid services to start.

County Social Services will not assume financial responsibility retroactively for services provided before eligibility is determined and funding is approved.

Services Covered by Iowa Health and Wellness Plan

The Iowa Health and Wellness Plan is one program that includes two separate coverage options. Eligibility is based on household income.

- *Iowa Wellness Plan:* Covers adults ages 19 to 64 whose income is at or below 100 percent of the Federal Poverty Level (\$957/mo. for individuals or \$1,292/mo.(214) for a family of two). The Iowa Wellness Plan is administered by Iowa Medicaid. Members will have access to the statewide Medicaid provider network which means they will have access to care from providers and hospitals in their local communities.
- *Iowa Marketplace Choice Plan:* Covers adults age 19 to 64 with income from 101 percent through 133 percent of the Federal Poverty Level (between \$957 and \$1,273 for individuals or \$1,292-\$1,719 (2014) for a family of two). The Marketplace Choice Plan allows members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid pays the premiums to the commercial health plan on behalf of the member. Members have access to the network of local health care providers and hospitals served by the commercial insurance plan.

To be eligible for the Iowa Health and Wellness Plan, you must:

- Be an adult age 19 to 64.
- Have income that does not exceed 133 percent of the Federal Poverty Level (\$15,282 for an individual or \$20,628 for a family of two, 2014 FPL).
- Live in Iowa and be a U.S. citizen.
- Not be otherwise eligible for Medicaid or Medicare.

Otherwise eligible individuals who need specialized medical services (such as those with complex medical conditions or mental, physical or developmental disorders) will be eligible for comprehensive coverage through Iowa's traditional Medicaid program with the option to enroll in the Iowa Wellness plan option.

The third option is for individuals over 133 percent of the Federal Poverty Level to purchase insurance on the "exchange." The exchange is subject to limited enrollment periods.

CSS and our MHCs have worked very hard to enroll individuals and will continue to do so. Individuals presenting to a MHC for the first time for services covered by health care reform will be told that they may be eligible for insurance and they must apply or risk termination of funding.

If they return for assistance the second time without following through on the application process, CSS will send a notice giving them 60 days to complete the application process, contact a CSS Office or risk termination of funding.

Individuals who do not qualify for the Iowa Health and Wellness Plan and missed the enrollment period for the “exchange” will be required to make application at a CSS Office and complete a Level 2 enrollment process to determine if they should remain eligible for funding until the next enrollment period.

Co-Payments Determinations

Any co-payments or other client participation required by any federal, state, region, or municipal program in which the consumer participates shall be required to be paid by the consumer. Such co-payments include, but are not limited to:

- Client participation for maintenance in a residential care facility through the state supplementary assistance program.
- The financial liability for institutional services paid by counties as provided in Iowa Code sections 230.15.
- The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.19.

Co-payments in this section are related to core services to target populations as defined in Iowa Code 331.397. No co-payment shall be assessed to consumers with income equal to or less than 150 percent of the federal poverty level (Appendix R Federal Poverty Guidelines), as defined by the most recently revised poverty income guidelines published by the U.S. Department of Health and Human Services.

Consumers with income over the established guidelines may be eligible for services on a sliding fee scale as shown in Appendix Q. A co-payment is required for those consumers with incomes between 150%-350% of poverty. This amount is collected by the service agency.

Level 2 Co-payments

Consumers who exceed income guidelines for Level 2 services will be assigned a monthly co-payment according to the following formula:

$$(\text{Unearned income} + (\text{Wages} - \$250)) - 150\% \text{ FPG} = \text{Monthly Co-payment}$$

Unearned income includes social security, FIP, pension, retirement and wages are any income received in the period for work performed. Co-payments will begin the first day of the month

following the determination and may be adjusted any time by presenting updated income information.

The CSS Board will review and approve the wage earner's disregard currently set at \$250 per month.

Mental Health Outpatient Treatment Co-payments

Co-payments for mental health outpatient will be assessed and collected at the time of service. The sliding fee scale must be used by any provider serving individuals with incomes above 150% FPL. CSS will only reimburse the agency their negotiated fee after deducting co-payments. Sliding fee schedule goes from 150% FPL to 350% FPL. Individuals below 150% cannot be assessed a co-payment. (Appendix Q)

Resource Limit Determinations

An individual must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multi-person household or follow most recent federal supplemental security income guidelines.

1. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this subrule.
2. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.
3. The following resources shall be exempt:
 - a. The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.
 - b. One automobile used for transportation.
 - c. Tools of an actively pursued trade.
 - d. General household furnishings and personal items.
 - e. Burial account or trust limited in value as to that allowed in the Medical Assistance Program.
 - f. Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.
 - g. Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.
4. If an individual does not qualify for federally funded or state-funded services or other support, but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:
 - a. A retirement account that is in the accumulation stage.
 - b. A medical savings account.

- c. An assistive technology account.
 - d. A burial account or trust limited in value as to that allowed in the Medical Assistance Program.
5. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

Utilization Review

CSS ensure that individuals are receiving the optimal level/site of care for their assessed needs and that this is reimbursable under the Plan. Services for individuals with mental health needs must be medically necessary as defined by IAC 441-79.9(2).

The Utilization Review process will use evidence based assessment tools (i.e. SIS for DD, ID and LOCUS for CMI, and Mayo Portland for BI) to assign individuals to one of six levels of care. Each level of care has a progressively intense array of service interventions to address individual needs. (Appendix P Level of Care Grid)

The level of care determination does not fix or cap services entitled to an individual.

The UR Coordinator will look at service plans, review level of functioning, social history and clinical assessment (psychological testing or psychiatric evaluation or History and Physical) and may also complete, or request that the Case Manager complete, an ICAP, LOCUS, or ASAM assessment tool.

If warranted the UR Coordinator may conduct a peer review with the assigned Medicaid Case Manager or Service Coordinator.

The UR Coordinator will conduct resource management in a supportive manner to enhance the quality of care and build consensus. Objective tools and analysis will be included in the review. The UR Coordinator and Case Manager must agree to any service changes. A qualified licensed professional will make the final determination if the parties to the review do not reach consensus.

Utilization Review Reports will be submitted regularly to the CSS Board with the following minimum data:

1. Number of clients enrolled.
2. Number of clients discharged.
3. Number of clients served.
4. Cost of services per member per month.

Waiting List Criteria

CSS may implement a waiting list if encumbered expenses for a given fiscal year exceed MH/DS funds available. Core Services for target populations shall be considered priority services.

Services and covered groups that exceed the core requirements may be placed on the waiting list.

Waiting lists may also be utilized if services requested are unavailable at the time of application.

If placed on a waiting list, the applicant shall be informed on the Notice of Decision form. The notice will identify the approximate time the service may be available to applicant. If unable to estimate such time, CSS shall state such and will update the applicant at least every 60 days as to the status of their service request.

Any waiting list that may exist shall be reviewed annually when planning for the future budgeting needs and future development of services.

Medical Necessity

The services must be medically necessary as defined in IAC 441-79.9(2):

- Be consistent with the diagnosis and treatment of the individual’s condition.
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the individual and be for reasons other than the convenience of the individual or the individual’s practitioner or caregiver.
- Be the least costly type of service that would reasonably meet the medical need of the individual.
- Be eligible for federal financial participation unless specifically covered by state law or rule.
- Be within the scope of the licensure of the provider.
- Be provided with the full knowledge and consent of the individual or someone acting in the individual’s behalf unless otherwise required by law or court order or in emergencies.
- Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441-Chapters 78 and 80.

Approved

County Social Services Board _____

Department of Human Services _____

Policy

CSS will compile an annual report for our stakeholders to assess our past performance and identify gaps, needs, changes for consideration of the next year's annual service plan and budget. CSS will comply with data reporting and other information technology requirements identified by the department.

Procedure

The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. Raw data will be collected and reported directly to the department by ISAC using the Community Service Network. This network will ensure data security. Information will be compiled and submitted to the department using the unique client identifier. The client identifier shall consist of the last four digits of an individual's social security number, the first three letters of the individual's last name, the individual's date of birth, and the individual's gender in an order determined by the department. CSN will collect and report the minimum data set as required by the department.

CSS will compile the annual report and present it for the October board meeting. Disability Coordinators will then present it to their communities and Advisory Groups through the month of November and December to solicit input for next year's annual service plan and budget.

The report will be finalized and submitted to DHS by December 1st (The initial report is due on December 1, 2015). The annual report shall include but not be limited to:

1. Data analysis to estimate the cost of serving non-mandated populations and projections on the cost of providing core disability services region wide to fully implement the disability response for the Aging and Disability Resource Center.
2. Demographic information, expenditure data, and data concerning the services and other support provided to each individual.
3. Services actually provided.
4. Actual numbers of individuals served.
5. Moneys expended.
6. Outcomes achieved.
7. Per member per year costs will be analyzed to project a case rate or capitated approach to funding long term support and services.

The annual report will also include legislative recommendations established by the CSS Board.

Approved

County Social Services Board _____