



Mental Health and Disability Services Redesign 2011

Intellectual & Developmental Disabilities Workgroup Minutes

Meeting #5

October 18, 2011, 10:00 am to 3:00 pm

United Way Conference Center

1111 9th Street, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Jim Aberg, Ron Askland, Bob Bacon (Co-chair), Mary Dubert, Marsha Edington-Bott, Dawn Francis, Stephanie Gehlhaar, Jan Heidemann, Terry Johnson, Roger Lusala, Mia Peterson, Susan Seehase, Rick Schults (sitting in for Co-Chair Karalyn Kuhns)

Legislative Representation: Dave Heaton, State Representative, House District 91 (Henry County) and House Chair of the Health and Human Services Appropriations Subcommittee

Facilitators: Lilia Teninty, Human Services Research Institute (HSRI)
Elizabeth Pell, Human Services Research Institute (HSRI)

DHS Staff: Connie Fanselow, Jennifer Harbison, Joanna Schroeder, Brian Wines

Other Attendees:

Reggie Ancelet	Options of Linn County
Bob Bartles	Hope Haven
Mardi Deluhery	Parent
Pat Deluhery	Parent
Diane Diamond	DHS Targeted Case Management
Kelly Espeland	IME Medical Services
Glenda Farrier	Cass Incorporated
Kyle Frette	Lobbyist
Zeke Furlong	House Democratic Caucus
Bob Hebl	Discovery Living
Linda Kellen	Department of Inspections and Appeals
Jeanie Kerber	DHS volunteer

Other Attendees (continued):

Amy Wallman Madden	H.O.P.E.
Michelle Moore	Harmony House
Jeff Morris	Imagine the Possibilities
Barbara Murphy	Harmony House/ABCM
Jim Nagel	Linn County provider
Sherri Nielsen	Easter Seals Iowa
Susie Osby	Polk County Health Services
J. Mark Roberts	Lutheran Services in Iowa
Rik Shannon	Iowa DD Council
Carol Warren	Progress Industries
Casey Westhoff	The Arc of Iowa
Dion Williams	Systems Unlimited

Agenda

Agenda Topics:

- Introductory Remarks and Overview of Agenda
- Review of results of Workforce meeting and recommendations
- Overview of best practice and trends in provider qualifications and provider monitoring
- Provider qualifications and monitoring discussion and key decision points
- Provider qualifications and monitoring recommendations
- Review of draft of preliminary recommendations summary document
- Next Steps
- Meeting Summary
- Public Comment

Meeting 5 Handouts:

- Meeting Agenda
- Best Practices in Provider Qualifications and Monitoring
- Preliminary Recommendations Adult ID Workgroup Summary
- Supports Intensity Scale Administration

INTRODUCTORY REMARKS AND OVERVIEW OF AGENDA

- Welcome by Rick Schults, MHDS Administrator, and introductions.
- Overview of agenda topics by Lilia Teninty.

Review of minutes from October 4:

- Page 12 – Jan Heidemann clarified that independent support broker services are available in Bremer County, and some housing or rental assistance is also available, but not necessarily to the extent it is in other places.
- Page 12 – Bob Bacon noted that the Direct Care Initiative has 5 career paths.
- Page 5 - Jim Aberg noted that the statement regarding time limiting pre-vocational services might not align with the new CMS interpretations.

- States need to be careful about time limiting services.
- Using person-centered practices, the team should be looking at what is an appropriate length of time, not having it arbitrarily limited by the state.
- “Time limited” will be clarified to reflect the concern that pre-vocational services cannot be viewed as the goal or final step, but a part of the employment process.

BEST PRACTICES IN PROVIDER QUALIFICATIONS AND MONITORING

Provider Qualifications:

- Provider qualifications establish a gate.
- The state has a gate-keeping function.
- Usually minimum expectations of:
 - Business license
 - Qualified CEO and leadership staff
 - Financial capacity to operate for a given time
 - Medicaid provider number
 - Policies and procedures to meet state and federal requirements
- Providers demonstrate the ability to maintain quality.
- Don’t want it to be too easy, which would allow sub-standard service provision.
- Don’t want it to be too hard, which would inhibit development and provision of needed services.
- Balance the need for quality with the need for service providers and building capacity.
- Different qualifications may be appropriate for different types of services.

Provider monitoring:

- Looking at how providers are performing.
- Expectation to meet federal and state requirements and contract provisions.
- States need authority to monitor and sanction.
- Collection of data to identify areas for quality improvement.
- Typically reviewed every 1 to 3 years (set by state).

General processes that are used for monitoring:

- Licensure – permission to practice; regulate certain activities.
- Certification – confirm certain characteristics of an organization.
- Accreditation – confirm competency, authority or credibility.

Monitoring yields important information about individual provider and system performance and looks at where additional supports are needed:

- Are there adequate numbers and types of providers?
- Are they qualified?
- Do they have sufficient staff capacity?
- Do they have effective management systems?
- Do they protect and promote rights?
- Do they demonstrate quality management?

Evolution of monitoring and current expectations:

- Monitoring has changed over the years as expectations have changed
- We have less centralized, more community-based services
- Less focus on physical facility
- Less prescriptive standards
- More public reporting of agency performance
- Wide variety of living environments
- Focus on looking at outcomes
- Continuous quality improvement – CQI
- Using information to make decisions
- Greater federal oversight
- U.S. Supreme Court's Olmstead Decision and, since 1999, Department of Justice enforcement of states' compliance with Olmstead
- Emergence of self-determination and self-directed services
- More involvement of stakeholders

What is it we want?

- Transparency
- Good monitoring tools and processes
- Publically laying out expectations
- Minimal disruption to peoples' lives and the functioning of the agency
- A streamlined non-duplicative process without gaps
- Use resources in the most effective way possible
- Accessible and available providers
- Process that flows easily for all people involved
- Supportive to providers in delivering excellent services
- Sharing data across multiple systems
- Encouraging and supporting agencies that are doing well
- Providing technical assistance to agencies that need it
- Removing agencies that do not demonstrate they can meet standards expected
- Making provider information available to individuals and families (examples: online restaurant ratings, CMS website containing quality of service information for Medicare-funded nursing homes, state report cards on provider services, etc.)
- Information is key for individuals and families in making decisions about services and providers

Value in gathering information from multiple sources:

- Good practice to have multiple data sources
- Can be challenging
- Important to ensure that the oversight entity is reviewing across sources
- Streamlined, non-duplicative and sufficient (no gaps)

States' use of accreditation to monitor provider performance:

- HRSI did a study of states' practices regarding national accreditation of community service providers; 46 state responded. Workgroup members received a copy of the report.
- Most states don't rely heavily on national accreditation independently of other sources of state quality monitoring. States recommend that national accreditation, when used, be used to complement not replace state quality monitoring.
- 30% require national accreditation
- 70% neither require or formally encourage national accreditation
- States are more likely to require accreditation of day services than residential services. States that require day service national accreditation are more likely to have had this requirement for over 10 years.

Discussion:

- For some types of facilities, accreditation is seen as meeting all necessary requirements; for ID/DD services, that is not the case.
- CMS expectations for facilities are very different from that for community-based services; different approaches.
- If you want to monitor for your state specific rules, national accreditation does not get you there.
- States can use accreditation, but it shouldn't be the only mechanism for measuring quality of a provider. It is one piece, not the whole pie.

Should we encourage national accreditation and rely on our own standards?

Who do we rely on to ensure that our standards are good?

- For provision of HCBS, need to follow what CMS requires.
- Federal government requires evidence of performance across 6 assurances for HCBS.
- State has the primary responsibility for monitoring.
- State makes assurances to CMS.
- CMS ensures the state is in compliance with the assurances.
- There is flexibility in how a state measures itself against the federal standards.
- Need to balance how to value accreditation vs. the states' overall QA standards.
- Some states enter into contractual agreements with national accrediting bodies to meet their particular needs.

Discussion:

- See accreditation as an important data point. The more data points we have the more confidence we can have in providers of services.
- Providers don't have the capacity to provide all services. They refer to other providers.
- Consumers have a choice as long as there is more than one provider available.
- There tends to be less choice in rural areas because there aren't necessarily enough users to support "competing" providers, especially the more specialized the service.

- There has to be a certain number of consumers available to support a provider's business.
- Providers have to have the capability to support the needs of the consumers seeking their services.
- What is there to challenge providers to continue to grow and expand the quality and variety of the services they offer?
 - Changing expectations of federal government, of people with disabilities and families, of advocates
 - What constitutes leading and best practices evolves over time
 - Providers who show the way to making changes
 - Changing the financial incentives to encourage growth/quality in targeted ways.
- As you get more self-advocates, businesses that try to continue to do things in the same way and do not change, will in effect close their own doors. They will not get referrals and consumers will not choose them.
- Rules and regulations do not promote excellence. From the business and service perspectives, you want to promote excellence.
- Business responds to the needs they see that they can fill.

Monitoring independent providers:

- CMS is encouraging the State to make self-direction a central feature of all waivers.
- How do states monitor the services of an independent provider who is hired and fired by the individual?
- Considerations:
 - Individual providers should meet essential basic qualifications.
 - Individual providers should have the training and specific knowledge to effectively support the person.
 - Tracking mechanisms should be in place:
 - Are services delivered according to plan (billing data)?
 - Is there a backup plan for when scheduled staff is unavailable?
 - Is the individual free of abuse, neglect, or exploitation?
 - Information about providers is readily available for individuals and families to make informed choices.

Workgroup members have been provided a report as a resource on how to monitor quality in a diffuse workforce.

Federal government monitoring requirements:

- Assurances for 1915(c) HCBS Waivers:
 - Needs are consistent with an institutional level of care.
 - Service plan is appropriate and services specified are received.
 - Providers of services are qualified.
 - Health and welfare is safeguarded and monitored.
 - Claims are paid according to state payment methodologies.
 - State Medicaid agency is involved in oversight and is ultimately responsible.

- Federal monitoring used to be a point in time review (snapshot).
- CMS has now gone to a more ongoing data analysis approach.
- The state Medicaid agency (IME) has the primary responsibility for maintaining compliance.
- Providers each submit an annual report to IME with evidence of compliance.
- IME submits an annual report to CMS.

Discussion:

- It is important to clarify what is meant by health and welfare.
- As providers try to serve more challenging individuals in an integrated setting, there are health and safety factors to be balanced with consumer choice.
- Not having a clear understanding can be a barrier to serving some individuals.
- Challenging that it is not federally defined either.
- Rules add on time and money.
- Those add-ons are not reflected in cost reports.
- Staff training is considered an indirect cost.
- Quality assurance activities and reviewing documentation before billing are also all indirect costs.
- A few years ago the 20% for indirect costs was adequate, but it is far from adequate now.
- Cost factors should be considered.
- CMS has assurances that states must meet.
- States have a lot of flexibility in how they do that.
- The challenge is how to best do it.
- This is an opportunity for DHS to tell the legislature how we can most efficiently meet the federal requirements for monitoring.
- The CMS assurances are the big picture, high level.
- There are also many sub-assurances that states must guarantee (including related to provider qualifications).
- The State needs to give interpretive guidance.
- The State has to set standards and show how they are measuring performance against the standards they have set.
- One of the things CMS requires is continuous open enrollment of service providers.
- Need a strong gateway.
- CMS has not promulgated minimum provider qualifications for waiver services. States have latitude in establishing qualifications. Like other Medicaid services, waiver services are subject to any relevant requirements contained in state law. Provider qualifications must be reasonable and appropriate in light of the nature of the service. They must reflect sufficient training, experience, and education to ensure that individuals will receive services from qualified persons in a safe and effective manner.

Performance outcomes measured by states to meet CMS HCBS Assurances:

- Accurate, timely and complete assessments.
- Look at risk planning and mitigation for health and safety.

- Individuals are involved in planning.
- The plan of care is up to date and timely.
- The plan of care is meeting the person's needs and preferences.
- Individual participants are safe.
- Individual participants have choice.
- Providers have competent staff.
- Management structures support effective and efficient operation.
- Data management systems produce useful information.
- There is continuous quality improvement.
- Providers have a responsibility to monitor themselves.
- They set goals for improvement and report to IME.
- The State sends aggregated data to CMS.
- CMS has expectation of 100 percent compliance with subassurances; when performance is below 100% compliance the state must describe its quality improvement strategy.
- It is a data driven process.
- How can we imbed consumers and family members into the quality monitoring process?

Current service quality monitoring in Iowa:

- Based on federal and state law and regulations.
- TCM satisfaction surveys (Iowa Code Chp. 24).
- All counties required to participate in QA activities (Iowa Code Chp. 25).
- Moved away from individual outcomes approach in surveying because of limited resources.
- Encouraging providers to get national accreditation.
- State reviews providers for state-specific standards.
- DHS reviews complaints.
- DHS conducts focused reviews that are issue specific.
- Quality review of direct services done at least once every five years; three years if state certified.
- Recognize licensure and certification.

Financial monitoring:

- Annual desk review by IME of cost reports for specific services.
- HCBS QA review of records for program integrity.
- DHS fiscal auditor looks at service documentation.
- County based financial audit of providers; providers submit annual audit reports.

KEY PROVIDER QUALIFICATIONS AND MONITORING QUESTIONS TO CONSIDER

- How can provider qualifications and monitoring efforts support desired outcomes?
- What expectations should the state have regarding quality improvement practices within provider organizations?

- What steps can be taken to measure individual outcomes across settings (i.e., ICFs/MR, community residences, etc.)? What is the best tool to use to monitor individual outcomes?
- Is the state's reliance on accreditation bodies sufficient to ensure quality?
- What data does the accreditation body make available to the state to ensure adequate oversight and remediation of problems?
- What monitoring functions are best performed at the local, regional and state level?
- To what extent can these functions be streamlined? What infrastructure changes or improvements would be needed to support this effort?
- What types of technical assistance can be made available to providers to enhance quality?
- What is the best way to make the information general from quality assurance efforts transparent? How should information be shared with the public?
- How can Iowa take advantage of existing resources?

GROUP DISCUSSION

Look at streamlining local, regional and state functions:

- What improvements or infrastructure changes are needed?
- How do we make information available to the public to make informed decisions?
- How do we do a better job with current resources?
- We've talked for years about having a single cost report, but we haven't gotten that done yet.
- Providers are required to submit an annual audit; everything on the audit goes onto the IME cost report for Medicaid services.
- Some counties, but not all, require additional cost reporting from providers.
- If each region comes up with its own way of reporting, we still won't have a uniform cost report.
- We need a uniform cost report.
- There is a whole separate SSA report for residential providers.
- We should be able to put this all together to provide the information that everyone needs.
- Rates should be consistent across the state.
- Most counties are willing to accept the IME cost rate when there is one.
- Cannot charge anyone less than what Medicaid will pay for the same service.
- There are some compliance issues in how Medicaid reimbursement is handled.
- Want to look at actual cost reports. Rate negotiation can be a different matter.

Recommendations:

- Consider provider cost related to compliance with quality monitoring efforts.
- Develop streamlined cost reporting standards statewide, inclusive of services and current reporting mechanisms.

Strengths:

- Waiver rules are flexible.

- Iowa providers are serving a lot of people at a low per person cost.
- Services are individually based.
- There is ongoing communication with case managers and focus on individual goals.

Challenges:

- Being able to separate regulatory pieces from technical assistance and best practices.
- Differences between the ID and DD populations in the service system.
- Consistency in interpretation of rules between and within oversight entities.
- Where does national accreditation fit?
- It is currently a condition of participation; a provider requirement.
- Information is not easily understandable or available.
- There is an onerous burden of paperwork and documentation. Clarify what is required and streamline.
- Clarify the definition of health and welfare.
- Need clear definitions and consistency in interpretation.
- Need more monitoring focus on outcomes and people; less focus on paperwork.
- Need to understand and interpret data.

PUBLIC COMMENT

Comment: Providers are in business and it is important to them to do good work and to be able to sustain their business. Sometimes it seems they are required to do things and to collect data that do not contribute to outcomes for the people being served.

Comment: I would like to comment on the means of providing data. If providers received a basic data package and could provide data in a way that we could also use it would make the process easier for everyone. My experience with accreditation is that it is collegial; focusing on best practices and helping providers I understanding benchmarks and quality and how to do things better. It should not be an adversarial or “gotcha” kind of process. State reviewers should work to help providers improve, not just be critical.

Comment: I have been a provider and a surveyor. There is some overlap between CMS and state rules and accreditation. I see them as complimenting each other. Part of accreditation is looking at how to do things and being proactive, not just compliant with regulations. I think accreditation can be a way to look at things differently.

Comment: There is a need for transparency to the public. For parents, most of their information comes from work of mouth. Rumors abound and information is not always accurate, so it is hard to make reasonable

informed decisions. Families need good, accurate, understandable information.

Comment: We have been CARF certified for 30 years. Parents and families never ask about that kind of certification. They want personal observation of programs and services. We are currently submitting six different cost reports. I have to clarify that the 20% for indirect costs is actually 16.67% and if we need to spend more than that, we don't get more.

Comment: I have been a member of the cost reporting committee for 12 years. We started out working toward a uniform cost report. It has been developed and is sitting somewhere at DHS. We still think it is the way to go. I am also a CARF surveyor. When states have a contract with CARF they can include some state specific elements in the process.

Comment: I want to avoid duplicative processes. Compliance and quality are two different things. The more rigidly and heavily regulated a service model is, the more difficult it is to deliver a quality service for people. I hope the key questions will be why are we doing what we are doing and how does it benefit people?

Comment: You mentioned competition between providers. In a town of 7,000, we have five supported community living providers but we are the only one accredited. We would like to have a minimum standard of excellence that all providers are required to meet.

Comment: Thanks to Representative Heaton for his comments and for putting business practice into this discussion. We still have to deal with capitated rates if providers are to remain viable. If we don't do something about hourly rates, more providers will be going away.

DISCUSSION OF RECOMMENDATIONS ON PROVIDER MONITORING

Recommendations:

- Make quality monitoring information easily available and understandable (i.e., website where consumers or family members could view what services are available and see provider "report cards").
- Establishing regulations that can be easily understood and are accompanied by clear interpretive guidelines to facilitate implementation with consistency.

Discussion:

- The concept of recoupment has made providers more defensive.
- It makes creativity more difficult because the state has rigid concerns about program integrity.
- The State and providers should function as a partnership, not "we vs. they".

Recommendation:

- Develop a partnership approach (less gotcha); look at technical assistance opportunities and resources and consider who should provide TA.

Discussion:

- The State should do monitoring.
- Should TA be done in a different way (i.e., really experienced providers working with IME to help providers who are in need assistance)?
- IACP is working with IME Bureau of Long Term Care on that kind of approach.
- Want consistent program evaluation that gathers the same kind of data.

Recommendation:

- Consistent data collection effort so information can be benchmarked and used for comparison purposes; tie information to technical assistance efforts.
- Data can be used to create report cards; benchmarking.
- Providers can compare to each other.
- Don't want to make extra layers.

Recommendation:

- Evaluate current provider qualifications and monitoring efforts to:
 - Identify duplications
 - Identify gaps
 - Streamline where appropriate
- Providers must balance health and safety measures with consumer rights.
- Need for interpretive guidelines.
- Many people are living with families or independently; yet, we have a model of health and safety and other requirements that are designed for facility-based care.
- Does requiring accreditation limit the number of providers who are willing to provide a service?
- How useful is it as a quality control measure?
- The cost might not be viable for everyone.
- There should be some incentive for providers securing accreditation.
- Accreditation as condition of inclusion as a provider?
- Or accreditation as attaining a level of excellence?
- Consider the implications of accreditation – what is the purpose?
 - Gate keeping function
 - Ongoing quality management function
 - Additional information about an agency

REVIEW OF PRIOR RECOMMENDATIONS

- Want to review each of the preliminary recommendations reached before today individually as a workgroup so that they can be submitted with a group consensus reached.
- See “Preliminary Recommendations” document for full text of draft recommendations.

REVIEW OF PRELIMINARY RECOMMENDATIONS DRAFT

WORKFORCE DRAFT RECOMMENDATIONS (page 5):

1. Make College of Direct Support available to ID/DD providers – agreed.
2. Require Direct Support Professionals to demonstrate 80% level of competence in the core curricula – agreed.
3. Provide financial incentive for securing voluntary certification – agreed.
4. All training as a direct expense – agreed.
5. Positive behavior supports available in each region – agreed.
6. Make technical assistance available to providers – agreed.
7. Cross train for co-occurring capability – agreed.

CORE SERVICES DRAFT RECOMMENDATIONS (page 3):

1. Current ID services should be core services – agreed:
 - Main intent was to say that if we didn't name something we don't mean it should end.
 - List current ID waiver services.
 - Don't want to miss residential services.
 - Services currently funded for any ID waiver recipient would not end.
 - Medicaid funded services?
 - Goal is to establish minimum statewide core services.

Recommendation:

- Specify current ID waiver services.
- Also add other state-wide services like ICF/MR and RCF/MR.
- Clarify that ancillary services could also be provided.

2. New core services to be added:

Discussion:

- Footnote re guardianships should be removed.
- What is meant by housing supports?
 - Counties now pay rent subsidies.
 - Some also have county-owned housing that is leased to providers who lease to consumers.
 - Iowa Finance Authority also has a rent subsidy fund.
- How would we set up mechanics?

- Should there be a statewide resource for finding housing?
- Helping people find affordable housing vs. dealing with the more challenging issue of funding for housing.
- Housing is a critical resource for community living. Explore how to make a cost effective model for decent, affordable housing for people with ID/DD available.
- Look at costs and prioritize recommendations that expand upon current services.
- Don't want to create an unfunded mandate.
- Don't want to limit the discussion only to the things we can fund today.
- Want to make sure recommendations include the things we think are important even though we know they will have to be expanded or made available over time as funds can be identified.
- "Prioritize and explore" – explore inclusion of these new services statewide.
- Items A (crisis prevention and intervention), B (Behavioral Intervention and Positive Behavior Support Services), and C (Mental Health Outreach) are in the process of being added by IME.
- Legislators need direction from the workgroup.
- It is not the intention that new core services are viewed as an unfunded mandate.
- Explore inclusion of these services on a statewide basis considering the resources available (both Medicaid and non-Medicaid).
- Make all services under the waiver available to the ID/DD population?
- More analysis needs to be done.

Recommendation:

- Exploration and further analysis of the inclusion of these services statewide for people with both ID and DD with consideration of both Medicaid and non-Medicaid resources available.
- Make it clear the exploration is for adding services for both ID and DD population.

3. Community First, Olmstead Plan priorities:

Discussion:

- Remove language after first clause of second sentence.
- Need to emphasize the positive to make choice possible.
- We need to ensure that people are not exploited in sub-minimum wage jobs and yet keep a range of employment options.
- Iowa needs to do all that it can do to make integrated supported employment a viable choice for people and more prevalent.
- Efforts need to continue to identify barriers to community living.

Recommendation:

- Add: "Explore, identify, and eliminate barriers currently experienced in Iowa that prevent achieving the promise of Olmstead."

4. Conflict free case management:

Discussion:

- Clarify what is meant by “conflict free” case management
- Need to look at SIS in conjunction with how it integrates with the CM process.
- Look at CMS language on person-centered service delivery; focus on strengths, interests, choices, etc.
- Need for accurate assessment.
- What is conflict free? What are the costs and benefits?

Recommendation:

- Change language to “explore development of conflict free case management” and add an explanation of conflict free according to CMS.
- Targeted Case Management is already looking at the overlap of SIS and the TCM assessment.
- What about management of case load size?
- Specify reasonable case load?

5. Employment Related Services:

Discussion:

- Pre-vocational “time limited” should be based on individual needs; not set time frames
- Remove qualifiers and just leave four item list
- Add “consistent with Olmstead” after “services”

OUTCOME MEASUREMENT DRAFT RECOMMENDATIONS (page 3):

1. Focus on positive outcomes for individuals and families – agreed.
2. Date aggregated, reported, and made public – agreed.
3. DHS staff resources to analyze data; establish a Quality Improvement committee – agreed.
4. Standardized and consistent consumer and family satisfaction surveys – agreed.

ELIGIBILITY DRAFT RECOMMENDATIONS (page 1):

1. Use of a standardized assessment tool for service planning and resource allocation – agreed.
2. Standardized process for determining eligibility.

Discussion:

- Is it intended for level of care only?
- Think it should apply to all factors.
- Focus on streamlining, eliminating redundancy and simplifying.
- Recommend taking out “including the used for Level of Care for the waiver”

3. Expansion of ID Waiver for DD population and consolidation of Waivers:

Discussion:

- Separate into two separate recommendations.
4. Use of clinical diagnosis and functional criteria for developmental disability eligibility – agreed, but change “autism” to “autism spectrum disorders”.
 5. Increased concentration on expansion of crisis services, applied behavior analysis, and positive behavioral supports – agreed.

PUBLIC COMMENT

Comment: In ICFs, if your costs go above the 80th percentile, you don't get paid for those costs. You might consider allowing costs to go above that level for facilities that are permanently downsizing. With the current cap on the rate, providers can't afford to do more supported employment. If the State would take the cap away, we could do more supported employment tomorrow. Illinois offers preferential contracts to encourage integration.

Comment: When you are looking at ICF/MR facilities, they are not all alike. Polk County has developed 4-bed ICFs/MR in existing homes in the community that don't look any different than any other homes on the street, but provide the ICF/MR level of care. Those should not be lumped into the large congregate care numbers because they are really are people who are living in the community. I have concern with having a SIS tool outside of case management because it seems to add another level of administration that seems redundant.

For more information:

Handouts, meeting information, and workgroup reports are be made available at:
<http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>