Iowa Department of Human Services

Iowa Mental Health and Disability Services Commission Combined Annual and Biennial Report for 2016

December 22, 2016

December 2016

Iowa Mental Health and Disability Services Commission

2016 COMBINED ANNUAL AND BIENNIAL REPORT

Report Contents:

INTRODUCTION

This Combined Annual and Biennial Report of the Iowa Mental Health and Disability Services (MHDS) Commission is submitted pursuant to Iowa Code § 225C.6(1)(h)-(i). The report is organized in three parts: (1) an overview of the activities of the Commission during 2016, (2) recommendations formulated by the Commission for changes in Iowa law, and (3) an evaluation of the extent to which services to persons with disabilities are actually available to persons in each county in the state and the quality of those services, and the effectiveness of the services being provided by disability service providers in this state and by each of the State Mental Health Institutes established under Chapter 226 of the Iowa Code and by each of the State Resource Centers established under Chapter 222 of the Iowa Code.

PART 1:

OVERVIEW OF COMMISSION ACTIVITIES DURING 2016

Meetings
The Commission held twelve regular meetings in 2016. The meetings included two sessions held jointly with the Iowa Mental Health Planning and Advisory Council. Meeting agendas, minutes, and supporting materials are distributed monthly to an email list of over 250 interested persons and organizations and are made available to the public on the Iowa Department of Human Services (Department) website. Commission meetings and minutes serve as an important source of public information on current mental health and disability services (MHDS) issues in Iowa; most meetings are attended by 10 to 20 guests in addition to Commission members and Department staff.

Officers
In May, Patrick Schmitz (Kingsley) was re-elected Chair of the Commission, and Marsha Edgington (Osceola) was elected Vice-Chair.

Membership
In May, Marsha Edgington (Osceola), Sharon Lambert (Coralville), Brett McLain (Ames), Marilyn Seemann (Woodward), Betty King (Cedar Rapids), and Rebecca Peterson (Clive) were each appointed to serve a second term. Richard Crouch (Malvern) completed his second term in April.

Administrative Rules
The Commission consulted with the MHDS Division on the development, review, and approval of three administrative rule packages. The packages were:

- Mental Health Advocate Rules – House File 468 directed the Commission, in consultation with Mental Health Advocates and county and judicial representatives, to adopt rules relating to advocates in their roles as county employees. Members of the Commission met with stakeholders twice in person and twice by phone to assist in the development of administrative rules. The rules were presented to the Commission in February to be adopted. A section of the rules was put on a session delay, and an amendment was presented to the Commission again in July, but not approved.
- Subacute Mental Health Facility Rules – Senate File 401 directed the Commission to adopt rules ensuring the geographic dispersal of seventy-five publicly funded subacute beds. Members of the Commission met twice by phone to assist in the development. The rules were approved for notice by the Commission in May, and approved for adoption in July.
- Autism Support Program Rules – House File 2460 made changes to the Autism Support Program in Iowa Code, and the Department made corresponding changes in administrative rule. A subcommittee of the Commission met once by phone to discuss the changes. The rules were approved for notice by the Commission in July, and approved for adoption in October.

MHDS Region Policy and Procedure Manual Review
In April, the Commission recommended to Department Director Palmer that a proposed change to the Central Iowa Community Services Policy and Procedure Manual be approved. The change was to send appeals to a central office rather than individual county offices.

In July, The Commission recommended to Director Palmer that a proposed change to the Rolling Hills MHDS Region Policy and Procedure Manual be approved. The change was to move toward community-based supported services rather than work activity services.

In December, The Commission recommended to Director Palmer that a proposed change to the South Central Behavioral Health Region be approved. The change was to increase the maximum limit for funding residential care from ninety days to 365 days without an exception to policy.

Service Cost Increase Recommendation
In August, the Commission was charged with formulating a recommendation for non-Medicaid expenditures growth funding to the Department and the Council on Human Services. The Commission recommended a 0.5% increase to account for the growth in Iowa's total population, and an additional 0.4% increase to account for inflation. These figures were based on the most recent census data and the inflation model used by the Substance Abuse and Mental Health Services Administration (SAMHSA) respectively. The Commission recommended the budget include funding to eliminate the Home and Community-Based Services (HCBS) waiver waiting lists and to direct a portion of the savings from the Mental Health Institution Realignment and the Medicaid Modernization Initiative to develop alternative care settings in the community.

Coordination with Other Statewide Organizations
The Commission held two joint meetings with the members of the Iowa Mental Health Planning and Advisory Council (IMHPC), and the two groups regularly shared information throughout the year. Mental Health Planning and Advisory Council Chair, Teresa Bomhoff, regularly attends Commission meetings, reports on IMHPC activities, and relays information between the Commission and the IMHPC. In May, Iowa Developmental Disbilities (DD) Council Public Policy Manager Rik Shannon presented an update to both groups on the activities and goals of the DD Council.

Coordination with the Iowa General Assembly
The Commission has four non-voting ex-officio members who represent each party of each house of the Iowa General Assembly. These legislative members attended meetings in person or by phone as they were able during the year.

REPORTS AND INFORMATIONAL PRESENTATIONS

During 2016, the Commission received numerous reports and presentations on issues of significance in understanding the status of services in Iowa and recognizing promising practices for planning and systems change, including:

IA Health Link Transition
In January, Deb Johnson from Iowa Medicaid Enterprise (IME) reported to the Commission on the transition to IA Health Link. She spoke about the Center for Medicare and Medicaid Services' (CMS) expectations for IME before approving the waiver allowing the transition to begin, how IME addressed those expectations, and worked with providers on changes in billing and reimbursement.

Delta Dental
In February, Gretchen Hageman from Delta Dental presented to the Commission on their contract to provide oral health services to Medicaid members. Gretchen outlined Delta Dental's network coverage, earned benefit components, and their commitment to improve oral and general health outcomes for Medicaid members.

IA Health Link Update
Also in February, Rick Shults, Division Administrator for MHDS, presented to the Commission on the Department's progress on gaining approval for Iowa's 1915 waivers.

Peer and Family Peer Support Training Program
In March, Lisa D'Aunno, Training Director for the National Resource Center for Family-Centered Practice at the University of Iowa School of Social Work and Karen Hyatt from MHDS reported on the progress the University of Iowa had made in training Peer Support Specialists (PSS) and Family Peer Support Specialists (FPSS) in Iowa. During the last year, the University of Iowa developed a curriculum for training, and trained forty-three PSS and thirty-two FPSS who are now certified. The Commission was discussed how to best utilize PSS and FPSS as well as make training and information more accessible.

Children's Mental Health Report
Also in March, Laura Larkin, Executive Officer for the MHDS Division, presented an overview of the Department Implementation Status Report Regarding the Mental Health Service System for Children, Youth and their Families including Iowa's Systems of Care programs.

State Innovation Model
Also in March, Marni Bussell of IME and Kala Shipley of the Iowa Department of Public Health (IDPH) presented to the Commission on the State Innovation Model (SIM) grant that Iowa receives from the Center for Medicare and Medicaid Innovation (CMMI). There was discussion of the State-Wide Alert Notification (SWAN) system that leverages data being collected and allow care teams to learn from it.

I-START
In April, Ashley Lutgen shared information with the Commission on the County Social Services Region's Systemic, Therapeutic, Assessment, Resources, and Treatment (START) program. START is an intensive case management strategy to wrap community-based services around people with more complex needs.

Olmstead Plan
In May, Connie Fanselow from MHDS presented to the Commission on the Department's progress in the development of a new Olmstead Plan. She spoke about the history of the Olmstead Supreme Court Decision, Iowa's approach to supporting community living for everyone, and including objective and outcomes data to reflect progress toward community living goals.

Community Connections Supporting Re-entry
Also in May, Caitlin Owens presented to the Commission about the Community Connections Supporting Re-entry (CCSR) program; a grant program aimed at reducing recidivism by connecting Department of Corrections personnel with resources in the mental health system to coordinate care for individuals leaving the corrections system.

Prevention of Disabilities Policy Council Transition
In June, Connie Fanselow presented to the Commission on the transition plan for the Prevention of Disabilities Policy Council (PDPC). The PDPC was directed to work with the Developmental Disabilities Council, the Department of Public Health, and the Commission to provide for the transfer of their duties to the other groups listed. The PDPC developed a plan that would provide for the transfer of their duties to various groups including the Commission, and the Commission approved a letter supporting the PDPC's plan.

Quality Services Development and Assessment
Also in June, John Grush spoke to the Commission about the Quality Services Development and Assessment (QSDA) initiative to collect outcomes data on individuals receiving mental health services.

Medical Assistance Advisory Council
In June, Mikki Stier, Director of Iowa Medicaid Enterprise, presented to the Commission on the Medical Assistance Advisory Committee (MAAC). She spoke about the structure, duties, and organization of the MAAC.

Community Mental Health Services Block Grant
In July, Laura Larkin and Mary Mohrhauser presented to the Commission on the Community Mental Health Services Block Grant (MHBG) and the First Episode of Care Set-Aside. They spoke about the grant application process, the allocation of grant dollars, and the success of the Recovery After Initial Schizophrenic Episode (RAISE) program.

State Resource Center Barrier Report
In August, Woodward State Resource Center Superintendent Marsha Edgington presented an overview of the Glenwood and Woodward State Resource Centers (SRC) Annual Report of Barriers to Integration for the calendar year 2015. This report originated as part of a settlement with the U.S. Department of Justice in 2004 to explain the reasons that people stay at the SRC and identify the barriers to moving into more integrated settings. The five major barriers have been identified as: (1) interfering behaviors, (2) under-developed social skills, (3) health and safety concerns, (4) lack of vocational opportunities or day programming, and (5) individual, family, or guardian reluctance. Annual planned reductions in number of SRC beds continue, with a focus on planning transition back to the community from the first day of admission and reducing the need for SRC admissions. Iowa's Money Follows the Person grant project has been an effective tool in supporting former SRC residents in their transition to community living.

Helping Families and Mental Health Crisis Act
Also in August, MHDS Division Administrator Rick Shults led a discussion on the Helping Families in Mental Health Crisis Act. The discussion included the elevation of the Substance Abuse and Mental Health Services Administration to an Assistant Secretary Position, amendments to the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights Privacy Act (FERPA), and support for Evidence-Based Practices (EBP) and promising research.

Department of Veterans Affairs
In September, Mardi Barnes presented to the Commission on mental health services available to veterans. She spoke about the broad array of services including suicide prevention hotlines, mental health, housing, and employment services available to veterans in Iowa.

IA Health Link Quarterly Report
Also in September, Liz Matney, Bureau Chief for Managed Care at Iowa Medicaid Enterprise, presented the first Quarterly Report to the Commission. She discussed areas of achievement, areas in need of improvement, and areas where further communication about data reporting should be developed.

PROFESSIONAL DEVELOPMENT ACTIVITIES

The Commission holds an annual two-day meeting each May, with the second day focused on training and development, which included:

Commission Duties
Theresa Armstrong reviewed the Commission's statutory duties, with particular attention to rule making and other specific responsibilities related to MHDS redesign and regionalization.

Ethical Considerations
Assistant Attorney General Gretchen Kraemer presented a review of Iowa's open meetings and open records requirements, and discussed conflict of interest, lobbying, communications, and other ethical considerations for Commission membership.

The Administrative Rulemaking Process
Harry Rossander, Department Bureau Chief for Policy Coordination, presented an overview of the Department's administrative rulemaking process with particular attention to the Commission's role in it.

COORDINATION WITH MHDS

MHDS Division Administrator Rick Shults, Community Services and Planning Bureau Chief Theresa Armstrong, along with other staff from the Division of Mental Health and Disability Services have actively participated in Commission meetings throughout the year, communicated regularly, provided timely and useful information, and been responsive to questions and requests from Commission members. A significant portion of each Commission meeting has been devoted to updates and discussion on variety of relevant issues and initiatives, notably including:

- Active Legislation regarding mental health and disability services
- Legislative Session & Interim Committee Reports
- MHDS Regional development
- County financial issues
- Equalization funding
- DHS budget, staffing, and services
- DHS facilities operations
- Crisis Stabilization Services
- Subacute mental health services
- Mental Health Community Services Block Grant
- Mental Health workforce issues
- IA Health Link and other Iowa Medicaid Program changes
- The Children's Mental Health and Well-Being Workgroup
- Medicaid Waiver Programs
- MHDS Requests for Proposals

PART 2:

RECOMMENDATIONS FOR CHANGES IN IOWA LAW IN 2017

Iowa's redesign of the State MHDS system resulted in the development of fourteen regional administrative entities. Innovative and expanded services have been made available in some regions. Some regions have developed or are providing additional "core-plus" services including residential crisis beds, 23 hour observation and holding, and or transition beds, mobile crisis, 24 hour crisis lines, mental health commitment prescreening and justice-involved services including mental health courts, jail diversion services, and mental health services in jails. Some are providing services to populations beyond those mandated such as to individuals with developmental disabilities and brain injuries. Thirteen regions are currently operating from positive fund balances acquired, in part from savings associated with the State assuming the costs of the Medicaid program in 2014. A few are facing having to cut additional "core plus" services due to insufficient funding associated with the fixed County levy rates dating back to 1996. These financial constraints due to the property tax levy restrictions have limited some regions in their expansion into additional "core plus" services. Equalizing the levy would allow for equitable access to services and supports.

In addition, the regions are not uniform in their approach to pooling of funds, nor is there consistency in the scope and accessibility of services beyond those classified as "core." Polk County and Eastern Iowa MHDS regions each received one-time funding from the State to help them maintain services.

Over the past 12 months most consumers of MHDS services, and the regions themselves have struggled to navigate a major system change in Iowa's Medicaid program as it transitioned to a managed care model. This Medicaid change has impacted accessibility of services, as most providers of regional MHDS services are also heavily reliant on the Medicaid system for financial support of service delivery.

Throughout this past year the MHDS Commission has monitored these developments and offers the following recommendations to the General Assembly in order to assure appropriate access to Iowans with mental health needs and other disabilities and to ensure the rights of all Iowans to receive supports and services in the community rather than institutions.

PROVIDE APPROPRIATE, PREDICTABLE, AND STABLE FUNDING

PRIORITY 1: Establish a stable and predictable long-term funding structure for mental health and disability services that is appropriate to fully implement the vision of redesign and to support growth and innovation over time.

1.1 Ensure that the savings to counties/regions from the Iowa Health and Wellness Plan are used to support regions in delivering core services and developing additional ("core plus") services in all areas of the state.

The MHDS Commission recommends this action because:

- The MHDS regions need stable and predictable revenues so that new services can be developed with the confidence that they will be sustainable.
- Growth in capacity will be necessary to enable the system to meet the needs of persons with developmental disabilities, brain injuries, or physical disabilities.
- The full impact of the change from legal settlement to residency, the adequacy of the $47.28 per capita levy formula, the effect of the introduction of Integrated Health Homes, and the long

term savings from the Iowa Health and Wellness Plan have not yet been established and funding needs should continue to be reviewed and evaluated.
- Regions will need resources to build and maintain a robust and sustainable array of crisis response services, which promise to divert people from emergency rooms, in-patient psychiatric treatment, and jails.
- Regions need flexibility; equalization funding could be discontinued if a statewide minimum levy rate for mental health and disability services was set and counties had the ability to set a higher levy rate with local support.
- Some regions are having difficulty funding their current service commitments.
- Some regions contain counties with wide variance in their levies, resulting in tension between member counties.

1.2 Ensure that provider reimbursement rates from all payers can be set at a level that is adequate to preserve service stability for consumers, build community capacity, and enable safety net providers (including community mental health centers and agencies providing substance abuse treatment) to offer and expand access to services that meet the complex needs of individuals served by the MHDS system.

The MHDS Commission recommends this action because:
- The successful implementation of MHDS redesign relies on the use of rate-setting methodologies that compensate providers for increasing their capacity to address the complex service needs of individuals and serving individuals with challenging behavior or support needs.
- As responsibility for payment shifts from counties to managed care organizations through IA Health Link, the availability of an adequate provider network and financial viability of safety net providers will depend on reasonable reimbursement rates from third party insurers.

1.3 Include transportation related to the delivery of mental health and disability services as a core service and reimbursable expense.

The MHDS Commission recommends this action because:
- Transportation is a vital component of access to all services. Many of the individuals served by the public mental health and disability services have few resources to arrange or pay for their own transportation.
- In most areas of Iowa, public transportation options are limited and the distances people must travel to service providers can be an insurmountable barrier to access if the cost of transportation is not covered.
- The availability of reimbursement would encourage the development of more transportation providers in areas where they are not currently available.

PRIORITIES REGARDING MEDICAID SERVICES

PRIORITY 2: Provide for a robust Medicaid Program with a full array of services that serves its members.

2.1 Assure that there is no shifting of financial responsibility or provision of services from IA Health Link to MHDS Regions or other entities.

The Commission recommends this action because:

- As responsibility for Medicaid payments to providers has shifted from the State to managed care organizations via IA Health Link, the availability of an adequate provider network and financial viability of safety net providers depends on timely and reasonable reimbursement from third party insurers. Providers have been forced to absorb additional administrative and transitional burdens, decreasing their operational effectiveness and risking their operations as a whole.
- The successful transition to IA Health Link should continue to monitor and prevent service changes that would result in consumers needing additional services and supports from MHDS Regions or others funders.
- Transportation, including but not limited to non-emergency medical transport, has been an obstacle to many Iowans being able to live, learn, work and integrate in their communities of choice.
- The MHDS Regions need stable and predictable responsibilities so that core services may be secured and additional "core plus" services developed and maintained in a sustainable manner.

2.2 Authorize funding to reduce the waiting lists numbers and waiting time for the Medicaid Home and Community Based Waiver program.

The Commission recommends this action because:

- Receiving a waiver slot no longer assures access because providers are increasingly declining to accept clients based on delays in reimbursement.
- Integrated Health Homes (IHH) must go through significant authorization process and if denied there is no compensation for this effort.
- Five of Iowa's seven HCBS Waivers – Brain Injury, Children's Mental Health, Intellectual Disability, Health and Disability, and Physical Disability – currently have waiting lists with individuals who applied over one year ago.
- As of December 9, 2016, there are 6,704 individuals on waiting lists for HCBS Waivers.
- As of December 9, 2016, the HCBS waiver for individuals with intellectual disabilities currently has a waiting list of 2,125 individuals.
- Individuals who remain on the waiting list for an extended period of time are at a higher risk of institutional placement, which is disruptive for families, expensive, and contrary to Iowa's goal of promoting individual choice and supporting inclusive community living.
- Individuals seeking services are not currently screened for eligibility and may apply for more than one waiver, so the actual number of eligible applicants waiting for services cannot be accurately determined; a pre-screening process at the time of application could identify those who are not eligible, refer them to other appropriate services, and eliminate them from the list.
- Individuals who are found to be potentially eligible in a pre-screening process could be triaged for services based on their level of need and risk of institutionalization.

PRIORITIES REGARDING A CHILDREN'S MENTAL HEALTH SYSTEM

PRIORITY 3: Expeditiously implement system-wide changes through the use of nationally recognized, evidence-based models of care.

The Commission recommends this action because:

- There is ample national evidence base for recommendations for system-wide change.
- Early intervention and prevention are well-accepted methods to reduce the incidence, prevalence, personal toll, and fiscal cost of mental health, intellectual disabilities, and developmental disabilities.

- An integrated service system for Iowa's children with serious emotional disturbances, intellectual disabilities, and developmental disabilities is overdue and critical to our most valued resource and could reduce costs to the adult mental health system.
- The inclusion of screenings to identify adverse childhood experiences (ACEs) during regular wellness visits with primary care physicians should be encouraged.
- The Commission strongly recommends that a more robust system of services which are readily available for children with developmental disabilities including intellectual disabilities be developed in a timely manner.

PRIORITIES REGARDING WORKFORCE CAPACITY

PRIORITY 4: Expand the availability, knowledge, skills, and compensation of professionals, paraprofessionals, and direct support workers as an essential element in building community capacity and enhancing statewide access to a comprehensive system of quality mental health and disability services.

Implement incentive programs to train, recruit, and retain professionals and paraprofessionals qualified to deliver high quality mental health, substance abuse, and disability services.

The Commission recommends this action because:

- The workforce shortage has been significantly increased since the launch of IA Health Link. Providers have lost a significant number of experienced staff to Medicaid MCOs.
- The shortage of psychiatrists and the barriers to accessing acute psychiatric care in our state are still readily apparent.
- Adequate funding and resource allocation is needed to ensure access to appropriate care throughout the state.
- Special incentives are needed to encourage and support Psychiatrists, Psychiatric Physician Assistants, Advanced Registered Nurse Practitioners, and other mental health and substance abuse treatment professionals who are trained in Iowa to stay and practice here.
- Special incentives could attract professionals trained elsewhere to practice in Iowa and encourage their retention.
- Professionals indicate that effective incentives include loan forgiveness programs and opportunities for fellowships; programs could be targeted to specific professionals and specialties that are most needed.
- Current loan forgiveness programs are restricted to areas that are designated as "Health Professional Shortage Areas," yet there is in need for additional mental health workforce at all levels throughout the state.

PART 3:

THE EXTENT TO WHICH SERVICES TO PERSONS WITH DISABILITIES ARE ACTUALLY AVAILABLE TO PERSONS IN EACH COUNTY IN THE STATE AND THE QUALITY OF THOSE SERVICES, AND THE EFFECTIVENESS OF THE SERVICES BEING PROVIDED BY DISABILITY SERVICE PROVIDERS IN THIS STATE AND BY EACH OF THE STATE MENTAL HEALTH INSTITUTES ESTABLISHED UNDER CHAPTER 226 AND BY EACH OF THE STATE RESOURCE CENTERS ESTABLISHED UNDER CHAPTER 222. (Iowa Code 225C.6(i))

EVALUATION OF THE STATE DISABILITY SERVICES SYSTEM

Report of the County and Regional Services Committee

When the Iowa Legislature passed Senate File 2315 during the 2012 session, counties were required to regionalize; plan, develop, and fund a set of core services; share state and local funding; and plan for expanded services and services to additional population groups as funds become available. Fourteen new mental health and disability service regions, have now been created through 28E Agreements, governed by members of county board of supervisors in consultation with representatives of provider agencies and clients and families. The implementation of the new system commenced on July 1, 2014. In the two years since the implementation of the regional system, counties have formed service regions, and begun functioning as collaborative systems. DHS is responsible for review and approval of the regional plans.

Other Changes Impacting the MHDS System

Iowa Wellness Plan: Implemented in January, 2014 as Iowa's response to the federal Affordable Care Act, the Iowa Wellness Plan provides comprehensive health coverage for low income adults ages 19- 64.

The Iowa Wellness Plan covers adults ages 19 to 64. Eligible member income is at or below 100 percent of the Federal Poverty Level. The Iowa Marketplace Choice Plan covers adults age 19 to 64 with income from 101 percent through 133 percent of the Federal Poverty through select insurers with plans on the Health Insurance Marketplace. Medicaid pays the premiums of the health plan for the member.

As of August 26, 2016, there were 142,272 people enrolled in the Iowa Wellness Plan. Access to full Medicaid coverage provides funding for important support services, including ACT (Assertive Community Treatment), Habilitation, Community Support, Intensive Psychiatric Rehabilitation, Peer Support, and Integrated Health Homes. The identification of individuals who qualify for the Medically Exempt status has been delayed by multiple application steps, locating individuals who may qualify and completing the application process, and the lack of claims data prior to January 1. Ongoing efforts are being pursued to simplify the process, to make health care providers and the community at large familiar with the process, and to utilize the claims data now available to identify and enroll eligible individuals. As more individuals qualify for Medicaid coverage through the Iowa Health and Wellness Plan, their ability to access needed services is improved. Concerns still remain, however, related to HCBS Waivers, which have lengthy waiting lists, as some individuals have remained on the list for over one year.

Medicaid Modernization: On April 1, 2016, three managed care organizations (MCO), Amerigroup Iowa, AmeriHealth Caritas Iowa, and UnitedHealthcare Plan of the River Valley assumed responsibility for providing services to the majority of Iowa's Medicaid members. As of August 26, 2016, Amerigroup had 184,134 enrolled members, AmeriHealth Caritas had 208,381 members, and UnitedHealthcare had 175,298 members.

Balancing Incentive Program: The Balancing Incentive Program (BIP) was a provision of the Patient Protection and Affordable Care Act that was designed to "balance" states' spending on long term supports and services (LTSS). Iowa began participation in the BIP program in 2012. The BIP included a collaboration with Iowa Department of Aging to streamline access to long term service and supports through Lifelong Links an integrated database of long-term services and supports (LTSS) to connect Iowans with appropriate resources to meet their needs. The BIP program ended in the fall of 2015.

Core Standardized Assessments: The Supports Intensity Scale (SIS) standardized assessment has been adopted as the functional assessment tool to determine if an applicant meets the level of care criteria for Intellectual Disability Waiver enrollment. The assessment is also used as a service planning tool to assist in identifying the supports and services members need to live successfully in the community. The interRAI suite of tools for standardized assessments for Elderly Waiver, Health & Disability Waiver, Brain Injury Waiver, Physical Disability Waiver, AIDS/HIV Waiver, Children's Mental Health Waiver and Habilitation which meet the Centers for Medicare and Medicaid Services (CMS) requirements for standardized assessments was selected by the Department.

CMS HCBS Service rules: The Centers for Medicare & Medicaid Services (CMS) issued regulations that define the settings in which it is permissible for states to pay for Medicaid Home- and Community-Based Services (HCBS). The purpose of the rules is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community. Providers of congregate care settings have developed transition plans in order to meet the criteria.

The State submitted an updated statewide settings transition plan (STP) to CMS on April 1, 2016. This transition plan incorporates changes made during the month of February 2016. The STP will cover the 1915(i) State Plan HCBS Program known as the HCBS Habilitation Services and all seven 1915(c) HCBS waivers which include, the Intellectual Disability, Brain Injury, Health and Disability, Physical Disability, Elderly, AIDS/HIV, and Children's Mental Health Waivers. The STP covers all HCBS services whether provided through the fee-for-services (FFS) delivery system or through IA Health Link, including any additional HCBS provided as "value-added" or 1915(b)(3) services through an MCO.

Iowa Olmstead Plan: The Department is in the process of gathering input and data to update the Olmstead Plan for Mental Health and Disability Services that was last revised in 2010. Department staff has been working with staff from the Center for Disabilities and Development and a committee of the Olmstead Consumer Task Force to redesign the plan framework, include background information on programs and initiatives, and identify data to objectively measure outcomes for Iowans with disabilities and progress toward plan goals. The revised plan will be released in 2017.

Service Access and Quality of Services

Regions: The regional system, although still in its infancy, has exceeded expectations in the development of core and additional "core plus" services. Drawing on county experience from the planning, funding, and delivery of mental health and disability services, regions have continued to offer stability in the MHDS service arena in spite of the changing environments, additional initiatives, and various partners. Regions are investing in providers to create and expand innovative services for residents, and are offering provider trainings in the area of trauma informed care, and evidence based practices. Regions involve local stakeholders in an advisory capacity to give them a voice in decisions that impact them.

Service Access: Regions submit quarterly reports on core access standards and monthly updates on additional cores services development to the Department's Division of Mental Health and Disability Services. These reports reflect the availability of services statewide.

Currently, all fourteen MHDS Regions offer some additional "core plus" services. There are ten regions with a twenty-four hour crisis line, eleven regions with facility-based crisis stabilization services, ten regions with jail diversion programs, ten regions with pre-screenings for individuals under civil commitment. Some regions are also offering mobile crisis response, crisis intervention training, and twenty-three hour crisis observation and holding.

Areas of Achievement

Regions also have recognized the additional requirements placed on them by the redesign legislation of 2012, and have introduced statewide solutions in answering these requirements and to create a unified vision and standardized approach to the operationalization of these tasks.

- **CEO Collaborative:** The Administrators of the fourteen MHDS Regions hold a monthly collaborative meeting with various partners throughout the state including: Peer and Family Support training development, Provider Association, Area Agency on Aging, Lifelong Links, AMOS (A Mid-Iowa Organizing Strategy), State Innovation Model (SIM), Iowa Olmstead Plan, and Managed Care Organizations.

Concerns and Identified Gaps

- Continued workforce shortage including unintended consequences of provider staff taking jobs with Medicaid MCOs
- Lack of timely access to a comprehensive array of services that can effectively serve individuals with severe multiple complex needs
- Change in how case management is provided for individuals on Medicaid in long term services and supports
- Closing of Mental Health Institutes psychiatric hospital beds resulted in a shift of responsibility for acute care settings to the community hospital network which currently lacks the ability to appropriately treat individuals with severe multiple complex needs
- An identified gap in community-based services for individuals with severe multiple complex needs
- The effects of the Centers for Medicare and Medicaid Services HCBS settings rules and Iowa's plan to achieve compliance to the rules on larger residential and vocational service settings.

Report of the MHI, SRC, and Disability Services Committee

After reviewing the available data in an effort to evaluate the effectiveness of the services being provided by disability service providers in this state and by each of the state mental health institutes and each of the state resource centers, the Commission concluded that information measuring the effectiveness of services continues to be limited. True evaluation of the services system requires qualitative data, as well as that quantitative information that is more readily available. Toward that goal, the Commission reviewed current measurements and offers recommendations for future statewide data collection.

The information currently gathered by the Mental Health Institutes and Resource Centers is primarily census data rather than qualitative measurements of satisfaction and outcomes. The number of discharges from State Resource Centers is available, but information on numbers of people are being moved from provider to provider due to problems with their service is needed to provide a complete picture of effectiveness and outcomes. Waiting lists only capture information on individuals who are

accepted on the waiting list. They do not capture any information on how many people did not apply for the list because they are in inappropriate places such as jails or hospitals because there are no other options available. Admissions and discharge data is available for the Mental Health Institutes, but there is no way to track where people are discharged to, and if they have a good outcome following their MHI treatment. Similarly, community providers currently gather their own programmatic data, but there is no statewide repository for such data and the provider data collection methodology and measurements vary. Counties have been required to gather statistical data for years. While this collection has been based on the same data requirements, analysis of the data with regard to potential outcomes has not been generated.

A statewide collaborative spearheaded by MHDS Regions and the Iowa Association of Community Providers and includes representatives from Medicaid MCOs, the Department of Human Services, and individuals familiar with the service delivery system, has begun collecting outcome data through the Quality Service Development, Delivery, and Assessment (QSDA) initiative. QSDA facilitates a statewide standardized approach to the development and delivery of quality MHDS services measured through the utilization of outcome standards. QSDA has identified four functions for statewide implementation.

- Implement service delivery models- learning communities, multi-occurring, culturally capable, evidence-based practices, and trauma-informed care.
- Work to ensure that providers are utilizing evidence-based practices and best practices.
- Identify and collect social determinant outcome data.
- Enter into performance or value-based contracts

The State Resource Centers have identified barriers in community provision of service related to moving individuals from residential care to care in communities of choice.

MHIs have identified a trend related to admission of patients who are increasingly aggressive resulting in longer stays due to difficulty in transitioning successfully back to home and community supports. When patients have longer stays these results in fewer bed openings for other individuals in need.

Both the MHIs and Resource Centers excel in providing services and supports to individuals who have high intensity interfering and aggressive behaviors as well as those who are medically fragile.

SUMMARY

There have been extraordinary changes to the MHDS system over the last two years. The implementation of MHDS Regional services, the expansion of Medicaid, and the shift to IA Health Link have transformed the system with the goal of more effectively and efficiently serving Iowans with disabilities and mental health conditions. The Commission also sees both opportunities and challenges in ensuring that service providers and funders continue to operate and meet the needs of Iowans across the state. We urge all stakeholders to recognize what has been accomplished and renew their commitment to work together to ensure that our MHDS system has adequate and predictable resources to meet the challenges of transition and growth, and to achieve high quality and long-term stability.

This report is respectfully submitted on behalf of the members of the Mental Health and Disability Services Commission.

Patrick Schmitz, Chair

Mental Health and Disability Services Commission Members 2016-2017		
Patrick Schmitz (Chair)	Community Mental Health Center Provider; Plains Area Mental Health Center	Kingsley
Marsha Edgington (Vice Chair)	Iowa Department of Human Services; Woodward State Resource Center Superintendent	Osceola
Thomas C. Bouska	Iowa Department of Human Services; Western Service Area Manager	Council Bluffs
Thomas Broeker	County Supervisor; Des Moines County	Burlington
Jody Eaton	County/Regional MHDS Services; Central Iowa Community Services CEO	Newton
Lynn Grobe	County Supervisor; Pottawattamie County	Oakland
Kathryn A. Johnson	Developmental Disabilities Services Provider; Abbe Center	Cedar Rapids
Betty B. King	Consumer advocate; Peer Support Specialist	Cedar Rapids
Sharon Lambert	Family advocate; Parent of a child consumer	Coralville
Geoffrey M. Lauer	Brain Injury Advocate; Brain Injury Alliance of Iowa	Iowa City
Brett D. McLain	Veterans' Advocate; Story County Veterans' Officer	Ames
John Parmeter	Provider of Children's Mental Health Services; Orchard Place	Des Moines
Rebecca Peterson	Service Advocate; Mental Health Counselor, House of Mercy	Clive
Michael J. Polich	Behavioral Health Association Provider; UCS Healthcare	Des Moines
Rebecca Schmitz	County Supervisor; Jefferson County	Fairfield
Marilyn Seemann	AFSCME representative; Psychology Assistant, Woodward State Resource Center	Woodward
Jennifer Sheehan	County/Regional MHDS Services; County Social Services, Coordinator of Disability Services	Clarion