

Iowa Department of Human Services



***Iowa Mental Health and Disability Services
Commission Combined Annual and
Biennial Report for 2018***



December 2018

Iowa Mental Health and Disability Services Commission 2018 COMBINED ANNUAL AND BIENNIAL REPORT

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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 2018

Meetings

The Commission held twelve regular meetings in 2018. 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 200 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, John Parmeter (Des Moines) was re-elected Chair of the Commission, and Kathy Johnson (Cedar Rapids) was elected Vice-Chair.

Membership

In May, John Parmeter (Des Moines) and Jody Eaton (Newton) were each appointed to serve a second term. Rebecca Schmitz (Fairfield) and Jennifer Sheehan (Clarion) completed their first terms in April and resigned from the Commission. Peter Brantner (Lenox) and Marilyn Seeman (Woodward) resigned from the Commission in April. In May, three new appointees joined the Commission: Mary Meyers (Madrid) was appointed to represent family member or guardian of an individual residing at a state resource center, Rick Sanders (Nevada) was appointed to represent county supervisors, and Richard Whitaker (Davenport) was appointed to represent community mental health centers. In July, two new appointees joined the Commission: Russell Wood (Hampton) was appointed to represent county/regional MHDS services and Lorrie Young (Mason City) was appointed to represent substance use disorder service providers.

Administrative Rules

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

- Autism Support Program Rules – House File 215 made changes to the Autism Support Program in Iowa Code, and the Department made corresponding changes in administrative rule. The rules were approved for notice by the Commission in January, and approved for adoption in April.
- Accreditation Rules– House File 653 made changes to the documentation requirements for community based providers in Iowa Code, and the Department made corresponding changes in administrative rule. The rules were approved for notice by the Commission in March, and approved for adoption in May.
- Developmental Disability Council Rules– The rules were a result of a general review of administrative rules to make necessary updates and simplify the content whenever possible. The rules were approved for notice by the Commission in June, and approved for adoption in September.
- Complex Needs Rules – House File 2456 directed the Commission to adopt rules related to MHDS regions core service domains which included service definitions, service provider standards, service access standards, and service implementation dates. Members of the Commission along with regional CEOs formed five committees with each committee meeting at least once in person or by phone and three committees met twice in person or by phone to

assist in the development of administrative rules. A public hearing was held on the rules on November 14. The rules were approved for adoption in December.

MHDS Region Policy and Procedure Manual Review

In June, the Commission recommended to Department Director Foxhoven that a proposed change to the Central Iowa Community Services Policy and Procedure Manual be approved. The change was to include Greene County to their policy and procedure manual.

In June, the Commission recommended to Director Foxhoven that a proposed change to the Heart of Iowa Policy and Procedure Manual be approved. The change was to remove Greene County from their policy and procedure manual.

In July, The Commission recommended to Director Foxhoven that proposed changes to the County Social Services Policy and Procedure Manual be approved. The changes were to update contact information and added HCBS waiver wait list criteria.

Service Cost Increase Recommendation

In July, 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 1.8% 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 that regional funding concerns be addressed.

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 Disabilities (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 2018, 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:

Complex Service Needs Workgroup Report

In January, Rick Shults, Division Administrator for MHDS, presented an overview of the Complex Service Needs Workgroup Final Report.

Children's Mental Health Report

Also in January, Laura Larkin from MHDS 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.

Autism Support Program Report

Also in January, Connie Fanselow from MHDS presented an overview of the Autism Support Program annual report.

Childserve Presentation

In February, Dave Comstock and Misti Johnson from Childserve presented on their services available to children in multiple locations throughout the state and gave an update on their expansion to include behavioral health services.

HCBS Settings Rules

In March, Debbie Johnson and Brian Wines from Iowa Medicaid Enterprise presented an update on the HCBS settings rules.

County Jails Administrative Rules

In April, Delbert Longley, the State Jail Administrator, presented an overview of the administrative rules regarding county jails and the requirements specific to individuals with mental illness, brain injury, or other disabilities.

Peer Support Services

Also in April, Betty King and Todd Noack presented an overview of peer support services including an explanation of peer support services, the benefits of the services, and how they could be used in Iowa.

Iowa Medicaid Update

In May, Mike Randol, Director of Iowa Medicaid Enterprise, presented an update on managed care and DHS oversight of the managed care organizations. He also spoke about the process for exception to policies and how IME can assist in workforce shortages.

Iowa State Sheriff and Deputy Association

In June, Tiffany Mass, Pottawattamie County Jail Administrator, presented to the Commission on mental health services provided in Pottawattamie County Jail. She also spoke about services that are available in other county jails and the differences between county jails.

Regional Jail Services

In July, Annie Uetz from Polk County Health Services (PCHS) presented on jail services available in Polk County and what PCHS is doing to educate jail and hospital staff on available regional services. Jody Eaton also presented a resource guide that was developed by the regions which is distributed to jail personnel.

Home and Community Based Services Waivers Eligibility

In August, Le Howland from Iowa Medicaid Enterprise presented an overview on the eligibility requirements and process for the HCBS waivers and Habilitation. She also spoke about the role of managed care organizations in the eligibility process.

Advisory Council on Brain Injuries

Also in August, Maggie Ferguson from the Iowa Department of Public Health presented an overview of the Advisory Council on Brain Injuries including their membership, responsibilities, programs, funding, and their five year plan.

University of Iowa's Center for Disabilities and Development

Also in August, Julie Christensen, Director of the Center for Disabilities and Development (CDD), presented to the Commission on CDD's programs, services, and initiatives. She also spoke about the needs assessment that CDD completed as part of developing their five year plan.

State Resource Center Barrier Report

In September, 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 2017. 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.

Iowa State Association of Counties

In October, Jamie Cashman, Government Relations Manager, presented on ISAC's legislative priorities regarding regional funding for the coming legislative session.

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.

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
- DHS budget, staffing, and services
- DHS facilities operations
- Crisis Services
- Community Services Mental Health Block Grant
- Mental Health workforce issues
- IA Health Link and other Iowa Medicaid Program changes
- The Complex Service Needs Workgroups
- The Children’s Mental Health and Well-Being Advisory Committee
- The Children’s System State Board
- Medicaid Waiver Programs
- MHDS Requests for Proposals
- Peer support services

PART 2:

RECOMMENDATIONS FOR CHANGES IN IOWA LAW IN 2019

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 and children.

Of great concern to the commission is the fact that 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.” This is contrary to the original intent of the regional concept. Polk County and Eastern Iowa MHDS regions each received one-time funding from the State to help them maintain services. Thirteen Regions are currently (as of 11/1/18) operating from positive fund balances acquired, in part from savings associated with the State assuming the costs of the Medicaid program in 2014. Senate File 504 requires the regions to spend down their fund balances by SFY 2021. The Commission is concerned this will negatively impact the stability of their funding and limit the ability of MHDS regions to provide innovative services. Additionally, the counties in several regions have reduced their property tax levy to zero to comply with Senate File 504 rather than establishing new services because they are concerned that they would not have sustainable funding to continue those new services.

The transition of Medicaid services to Managed Care Organizations has negatively impacted the accessibility of services. The concept was described by policy makers as one to improve accessibility and this is clearly not been achieved based on consistent reports and evidence of decreased accessibility, availability and affordability of care and services as well as quality of life. Most providers of regional MHDS services are heavily reliant on the Medicaid system for financial support of service delivery, and there has been a substantial increase in delays of payment and the denial of payment for services provided over the last year. While claims are processed, in many cases providers are paid a reduced reimbursement rather than receiving full payment of the contracted amount.

Throughout this past year the MHDS Commission has continued to monitor these developments and offers the following recommendations to the General Assembly in order to assure appropriate access to lowans with mental health needs, intellectual and developmental disabilities and brain injuries to insure the rights of all lowans to receive supports and services in the community rather than institutions and to insure that there is a genuine focus on maintaining and increasing the quality of life of lowans served.

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, in developing additional (“core plus”) services and expansion of services to additional populations, such as developmental disability and brain injury in all areas of the state. In addition, the requirement of Senate File 504 for the elimination of fund balances resulting from the saving to counties/regions should be repealed, as should the restriction on the county property tax levy cap for MHDS.

The MHDS Commission recommends this action because:

- The MHDS Regions need stable revenue and a funding system that allows them to continue to provide current services and gives the flexibility to develop new and innovative services
- Growth in capacity will be necessary to enable the system to meet the needs of persons with developmental disabilities, brain injuries, or physical disabilities.
- Regions will need resources to build and maintain a robust and sustainable array of crisis services and services for individuals with complex needs, which promise to divert people from emergency rooms, in-patient psychiatric treatment, and jails.
- There is a wide variance in levies between the MHDS regions and a wide range of difference in care and services. Thus a repeal of a levy cap allows the counties, and thus regions, to respond to the needs for care and services is recommended.
- In order for braided funding to be sustainable, there should be a process to determine how funding can be braided and the responsibilities of each party clearly defined

1.2 Ensure that provider reimbursement rates from all payers are 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:

- Due to lack of workforce, provider reimbursement must be adequate to also allow providers to offer wages, employment benefits and ongoing training which will serve to attract and retain qualified staff.
- In many cases claims are processed, but providers are paid a reduced amount of reimbursement rather than full payment of the contracted amount.
- The successful implementation of MHDS redesign, as well as the recent mental health services established by HF 2456, 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.

- Reimbursement rates for many services have not been increased in four years, and the current rates do not cover the increased costs of service provision related to inflation.
- The availability of an adequate provider network and financial viability of safety net providers will depend on reasonable reimbursement rates.
- The reduction of reimbursement based upon individualized service needs or as identified in the individual's service plan has reduced the availability and access to needed services.

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 and essential to support community-based service and quality of life. 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 increased accessibility to transportation in all areas.

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. 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 be monitored to prevent service changes that result in individuals 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 funding responsibilities of MHDS Regions need to be clearly and consistently defined so that core services may be secured and additional services developed and maintained in a sustainable manner.
- Ongoing monitoring and oversight of managed care organizations are needed to ensure there is an adequate network of providers. A clear definition of an adequate network needs to be developed and enforced.

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.
- 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 1, 2018 there are 8,247 individuals on waiting lists for HCBS Waivers.
- As of December 1, 2018, the HCBS waiver for individuals with intellectual disabilities currently has a waiting list of 2,227 individuals.
- Individuals who remain on the waiting list for an extended period of time are at a higher risk of institutional placement, which is damaging 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 remove 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.
- Individuals who remain on the waiting list for an extended period of time often have a dramatic decrease in health as well as quality of life.

2.3 Assure continued efforts to provide choice of membership to managed care organizations

The Commission recommends this action because:

- On November 30, 2017, Amerihealth Caritas withdrew from the state of Iowa as a managed care organization. This change impacted 215,000 Iowans.
- In November 2017, Amerigroup reported they were at capacity and unable to accept additional members. Members being served by Amerihealth Caritas were then automatically assigned to United Health Care. Members who chose Amerigroup were assigned to DHS as fee for service until March 1, 2018 when they transferred to Amerigroup. Amerigroup began receiving new enrollees on May 1, 2018.
- In May 2018, DHS announced that Iowa Total Care will begin providing services as a managed care organization on July 1, 2019.
- Medicaid clients should have full open enrollment anytime a MCO is added, removed or departs from the state.
- Medicaid clients should be provided with an independent managed care insurance "navigator" to support informed choice.

2.4 The impact of waiving the 90-day retroactive coverage should be gathered and the decision to waive retroactive revisited

The Commission recommends this action because:

- The loss of retroactive coverage has negatively impacted thousands of Iowans.
- Access to mental health and disability services and supports for individuals with disabilities has been reduced.
- The cost of care for individuals who are in the process of determining Medicaid eligibility has shifted to local providers with no way for many providers to recover reasonable expenses through adequate and/or timely payment.

PRIORITIES REGARDING A CHILDREN'S MENTAL HEALTH SYSTEM

PRIORITY 3: Expediently implement a children's mental health and disability services system which has sustainable funding and which utilizes a full array 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 array of services should include routine screenings for all children to identify those who have increased risk of suffering mental illness and/or disabilities and those who have been identified should have timely referral for appropriate services.
- 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 continues and has worsened over the past year.
- 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.
- Direct care wages, benefits and training are not, and must be competitive
- 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.

PRIORITIES REGARDING DEPARTMENT OF HUMAN SERVICES

PRIORITY 5: Enhance DHS computing infrastructure and staffing for provider accreditation and data analysis of the mental health and disability services system.

The Commission recommends this action because:

- Unbiased metrics and data analytics are necessary to move toward a value based reimbursement structure.
- The State must evaluate, on an ongoing basis the implementation of evidence-based, evidence supported and promising practices.

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 became available. Fourteen new mental health and disability service regions were created through 28E Agreements, governed by members of county boards of supervisors in consultation with representatives of provider agencies and clients and families. The implementation of the new system commenced on July 1, 2014.

The Regions’ 28E agreements provide for some flexibility in a county’s ability to change regions. Greene County left the Heart of Iowa Region and Joined Central Iowa Community Services July 1, 2018. The pending withdrawal of Woodbury County from the Sioux Rivers Regions has created opportunities for realignment in that area of the state. Lyon County plans to leave NorthWest Iowa Care Connections and join Plymouth and Sioux Counties in Sioux Rivers MHDS July 1, 2019. Legislation in 2018 allowed counties in the County Social Services (CSS) Region to break away and organize an additional region. That option was explored however it appears that most counties will remain with CSS for FY 2020. The recent realignment of counties into other regions has caused some concerns over the stability of this structure moving forward.

Legislative Changes

During the 2017 legislative session, SF 504 required the 14 MHDS Regions to convene stakeholder workgroups that included representatives from law enforcement, mental health and substance use

disorder providers, hospitals, the judicial system, the national alliance on mental illness (NAMI), and other entities as appropriate. The workgroups were to:

- Create collaborative policies and processes related to the delivery of, access to, and continuity of services and supports for individuals, particularly for those with complex needs,
- Review resources currently available and plan for meeting the fund balance criteria included in the legislation,
- Examine existing services and supports available, identify gaps, and recommend funding priorities, and
- Submit their recommendations in the form of the “Complex Service Needs Regional Community Plans”.

The legislation also required that Regions and Managed Care Organizations enter into Memorandums of Understanding to define the roles and responsibilities of each party in the areas of member care coordination and provider network management.

SF 504 also created a statewide workgroup co-chaired by the Department of Human Services and Department of Public Health that included representatives from law enforcement, mental health and substance use disorder providers, hospitals, the judicial system, NAMI, and the MHDS Regions. The statewide workgroup created “The Complex Needs Workgroup Report” which resulted in the passing of HF 2456. HF 2456 named the regions responsible for providing access to and funding intensive crisis services, access centers, assertive community treatment, and intensive residential service homes. The legislation requires a minimum of:

- 6 Access Centers that include:
 - Assessment capabilities,
 - Residential subacute,
 - Residential crisis stabilization, and
 - Direct access to substance use disorder treatment
- 22 Assertive Community Treatment Teams, and
- Intensive Residential Service Homes for 120 slots.

These intensive services will require careful investment and multi-party collaborations in order to have successful outcomes.

The legislation added these much needed services but fell short of identifying stable ongoing funding.

Other Changes Impacting the MHDS System

Iowa Health Link: 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. On November 30, 2017, AmeriHealth Caritas Iowa withdrew from the state as an MCO. There was also the loss of local conflict free case management. In May 2018, the state announced that Total Care Iowa will begin providing services in Iowa as an MCO on July 1, 2019.

State Innovation Model (SIM): In 2014, Iowa was one of eleven recipients of the State Innovation Model Testing grant. Iowa was awarded \$43.1 million over a four year period. Iowa’s plan for health system transformation builds upon the ACO model that currently covers the Iowa Wellness Plan population. Through the SIM program, Iowa will focus on two primary drivers; Aligning payers in value based purchasing (VBP) to effectively move the healthcare system from volume to value and

equipping providers to engage in population health needs and focus on value outcomes. The state is currently working with managed care organizations to be in compliance with VBP requirements.

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. States are required to have the new rules implemented by 2022 and Iowa is on track to meet that deadline.

Iowa Olmstead Plan: The Department worked 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 five year plan runs from 2016 - 2020.

Service Access and Quality of Services Regions

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.

- All 14 regions either have developed or contract with another region for Crisis Stabilization Beds.
- Six regions have Mobile Response with an additional six regions in the planning stages.
- Twelve regions currently have 24-hour Crisis lines.
- 23 hour Observation, and Subacute Service are also available.

Additional core services developed by the regions include Jail Diversion programs and pre-screenings for individuals under civil commitment. Some regions are also offering Crisis Intervention Training for law enforcement.

Areas of Achievement: The MHDS Regions continue to surpass expectations in the development of core and additional "core plus" services. Initially there was an intentional investment into Community Based Services by the MHDS Regions to meet access standards. The focus in the last 2 years has largely been in the area of Crisis and Diversion Services. HF 2456 moved Crisis Services into the core service domain and are now a requirement of the regional service array such as Mobile Response, 23 hour observation, Crisis Stabilization, and Subacute Services.

Concerns and Identified Gaps

- Continued workforce shortage including direct care staff
- Challenge for Managed Care Organizations in correct and timely payments to providers along with addition to pre-authorization requirements, payment rates
- 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 who are eligible to receive case management services

- The lack of intensive psychiatric hospital beds that shifts 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
- The effects of the Centers for Medicare and Medicaid Services Home and Community Based Services 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 (MHIs) and Resource Centers (RCs) 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. As of 11/19/18, the combined census of the two RCs was 341 (245 males and 96 females), of which 4 are minors. In SFY 18 the RCs admitted 14 individuals. In SFY18 the RCs discharged 8 individuals, 5 to HCBS/ID Waiver settings, 2 to smaller community based ICF/IDs and 1 to the home of family-relative. The RCs do not track average length of stay.

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. As of 11/19/18, capacity and census of Cherokee Mental Health (CMHI) was 36 (19 males and 17 female), of which 12 are minors. As 11/19/18, capacity of Independence Mental Health (IMHI) is 58 and census was 56 (27 males and 31 females), of which 17 are minors. The average length of stay at CMHI during SFY18 was 55 days. The average length of stay at IMHI was 131 days. In SFY18, CMHI admitted 358 and discharged 357; IMHI admitted 160 and discharged 159. Discharges from MHIs have gone to a variety of settings; detention center, foster home, group home, hospital, jail, juvenile shelter, living alone, no entry, PMIC, private residence, RCF, residential care facility, residential correctional facility, state correctional facility, supervised apartment, with family-relative, with friends or other. It should be noted that approximately 55% of discharges from MHIs are to family-relative and overall there have been as many discharged as admitted to the MHIs during SFY18.

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. Incidents of staff injury of all types, all levels of injury (ranging from minor superficial scratches to broken bones), and all causes of injury (not just patient/individual aggression) for the period of October 2017 to October 2018 by facility are; CMHI-91, IMHI-45, GRC-219 and WRC-259.

SUMMARY

There have been extraordinary changes to the MHDS system over the last two years. The development and expansion of core services and regional collaboration have transformed the system with the goal of more effectively and efficiently serving lowans 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 lowans 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.

John Parmeter, Chair

Mental Health and Disability Services Commission Members 2018-2019

John Parmeter (Chair)	Provider of Children's Mental Health Services; Orchard Place	Des Moines
Kathryn A. Johnson (Vice Chair)	Developmental Disabilities Services Provider; Abbe Center	Cedar Rapids
Thomas C. Bouska	Iowa Department of Human Services; Western Service Area Manager	Council Bluffs
Thomas Broeker	County Supervisor; Des Moines County	Burlington
Dennis Bush	County Supervisor; Cherokee County	Cherokee
Jody Eaton	County/Regional MHDS Services; Central Iowa Community Services CEO	Newton
Marsha Edgington	Iowa Department of Human Services; Woodward State Resource Center Superintendent	Osceola
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
Mary Meyers	Family advocate; Parent of a resident at a state resource center	Madrid
Rebecca Peterson	Service Advocate; Mental Health Counselor, House of Mercy	Clive
Rick Sanders	County Supervisor; Story County	Nevada
Russell Wood	County/Regional MHDS Services; Central Iowa Community Services Disability Coordinator	Hampton
Richard Whitaker	Community Mental Health Center; Vera French	Davenport
Lorrie Young	Substance Use Disorder Treatment Provider; Prairie Ridge	Mason City