

Iowa Certified Community Behavioral Health Clinic Planning Grant Abstract

The Iowa Departments of Human Services and Public Health are partnering to lead the state's Certified Community Behavioral Health Clinic (CCBHC) project. In the Planning Grant year, the departments will convene representative stakeholders to advise on a range of planning activities. Implementation of the planning activities will lead to readiness for CCBHC implementation, certification of two to four CCBHCs, an approved prospective payment system (PPS), and a successful CCBHC Demonstration application. Iowa plans to use the PPS-1 methodology to establish CCBHC-specific rates that provide reimbursement of cost on a daily basis.

Iowa's CCBHC target population is adults with a serious mental illness, children with a serious emotional disturbance, adults with long-term substance use disorders, and individuals seeking mental health and substance use disorder treatment in the selected CCBHC regions. The number of people that will be served annually is dependent on the number of CCBHCs ultimately selected and service utilization in their regions.

Statewide 18.4% of adults, aged 18 and over, had Any Mental Illness (AMI) in the past year compared to 18.2% for the United States (2014, The NSDUH Report). According to the 2010 BRFSS, binge drinking is higher in Iowa (18.5%) than in the U.S. (15.8%). The 2012 State of Iowa Substance Use Epidemiologic Profile identified alcohol as the most reported substance of use on admission, 672 per 100,000 which is significantly higher than the next highest, marijuana at 383 per 100,000. Iowa anticipates that evaluation of CCBHC will result in improved, more effective treatment approaches for these individuals.

Services for veterans and American Indian/Alaskan Native (AI/NA) will be addressed during the planning year. Veterans comprise 7.4 % of Iowa's population. Iowa had 14,742 Native Americans and Alaska Natives living in the state in 2013. State-specific mental health and substance use data for these populations is not available, but nationally, veterans and AI/NA have higher than average suicide rates and substance use disorder.

Iowa's CCBHC project will be integrated with the Iowa High Quality Healthcare Initiative (Medicaid managed care), the State Innovation Model, value based purchasing, accountable care organizations, integrated health homes, and addictions service system transition.

Iowa will use the CCBHC to strengthen the state's behavioral health services, improve service capacity, and test the CCBHC model. Testing of CCBHCs will be used to further improve the integration of physical and behavioral health care for individuals with mental illness and/or substance use disorder. It will also help improve alignment between mental health and substance use disorder services, increase proficiency in use of evidence based practices, and increase service delivery standardization. The CCBHC stakeholder engagement, technical assistance and learning community opportunities, and certification readiness activities will aid in developing solutions and improving outcomes for selected clinics and other participating providers.

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Section A: Statement of Need

A-1. Iowa behavioral health services: organization, funding, and provision

The State of Iowa embraces the Certified Community Behavioral Health Clinic (CCBHC) opportunity. CCBHC Planning Grant funds will allow Iowa to advance state-level system improvement efforts, and achieve goals related to alignment of mental health (MH) and substance use disorder (SUD) services, payments and delivery systems. Iowa is committed to working with SAMHSA during the CCBHC planning year to align planning year activities with complementary initiatives Iowa is currently undertaking to improve outcomes and quality, including the Iowa High Quality Healthcare Initiative, the State Innovation Model (SIM), creation of accountable care organizations, the addictions service system transition, and value based purchasing. By managing these initiatives collectively, Iowa will accelerate progress toward achieving targeted outcomes, improving the lives of Iowans, and evolving the behavioral health services infrastructure in the state.

Iowa structures behavioral health services across the lifespan through three state-level authorities: (1) Mental health services are administered by the Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS); (2) Substance use disorder services (SUD) are administered by the Iowa Department of Public Health Division of Behavioral Health (IDPH); and (3) Medicaid services are administered by the DHS Iowa Medicaid Enterprise (IME). Although DHS and IDPH are separate in terms of organizational structure, the agencies collaborate extensively to develop service coverage and payment policies for publicly-funded behavioral health services. For the CCBHC initiative, DHS MHDS will be the applicant agency, and IDPH and DHS IME have agreed to participate fully to support the achievement of project vision and goals.

SUD Services Administered by the Iowa Department of Public Health (IDPH): IDPH is Iowa's state substance abuse authority (SSA). IDPH is responsible for licensure of all SUD treatment programs, and for administration of state SUD appropriations and the Substance Abuse Prevention and Treatment Block Grant. Providers must be licensed by IDPH to provide SUD services in Iowa. IDPH directly pays eligible SUD providers for certain services and pays for treatment services paid for by state or federal block grant funds through the Iowa Plan for Behavioral Health, described below under *Medicaid Behavioral Health Services Administered by DHS IME*. Medicaid financing and provider payments for the Medicaid SUD benefit are distinct, as also described below.

MH Services Administered by the Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS): MHDS is the state mental health authority (SMHA) in Iowa. MHDS is responsible for the accreditation of community mental health centers (CMHCs), mental health service providers (MHSPs) and certain non-behavioral health service providers. MHDS is also responsible for the administration of state MH appropriations and the federal Mental Health Block Grant. Iowa's CMHCs and MHSPs must be accredited by MHDS to provide services. MHDS directly pays eligible CMHC and MHSP providers for services delivered under state-only or federal block grant funds. Medicaid financing and provider payments for the Medicaid MH benefit are distinct and described below under *Medicaid Behavioral Health Services Administered by DHS IME*.

Medicaid Behavioral Health Services Administered by the Department of Human Services (DHS) Iowa Medicaid Enterprise (IME): IME is Iowa's state Medicaid authority (SMA) charged with administering, monitoring and paying providers for services available under the state's Medicaid benefit. Since 1995, while retaining ultimate responsibility and oversight for these services, DHS and IDPH have contracted with a behavioral health managed care organization (MCO) that is responsible for administration and management of Medicaid-covered MH and SUD benefits provided to the majority of Medicaid enrollees statewide, and certain IDPH-funded SUD services. The state's managed behavioral health plan is called the Iowa Plan for Behavioral Health (or Iowa Plan). Iowa Plan members access MH and SUD services through providers contracted with the Iowa Plan MCO. Contracted providers include accredited CMHCs and MHSPs and licensed SUD programs. The Iowa Plan MCO also contracts directly with licensed independent practitioners (e.g., psychiatrists, psychologists, licensed social workers, etc.). Eligible MH and SUD providers under contract for the Iowa Plan receive payments for Medicaid behavioral health services and IDPH-funded SUD services directly from the MCO. IDPH and IME collaborate with MHDS to establish behavioral health services coverage policies. In 2012, Iowa received CMS approval for its Medicaid integrated health home (IHH) benefit for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). The IHH is designed to improve holistic care coordination for Iowans with an SMI or an SED. The remainder of the IHHs are MH, case management, and child-serving agencies. IHHs provide care coordination through a team-based approach. Teams consist of a care coordinator, a nurse, and a peer support or family peer support specialist. This model of care coordination fulfills targeted case management requirements for Iowans with SMI/SED eligible for HCBS services. Iowa currently has 39 Integrated Health Homes, 10 of which are both accredited CMHCs and licensed SUD programs, 13 which are accredited CMHCs, and five that are licensed SUD programs. Early and promising results of IHH services indicate that member use of emergency departments for mental health services dropped 16% and MH inpatient admissions dropped 18%. The IHHs have strengthened the ability to plan and execute a more integrated, person-centered system that can better address consumer health, social, and environmental needs in a coordinated delivery system. The implementation of IHH services lays a strong foundation upon which to successfully build CCBHCs.

Beginning January 1, 2016 IME plans to implement the Iowa High Quality Healthcare Initiative, a significant change in the delivery of Medicaid-covered services in Iowa. DHS expects to announce in mid-August award of statewide contracts with two to four MCOs that have a demonstrated capacity to coordinate care and provide quality outcomes for the Medicaid and Children's Health Insurance Program (CHIP) populations. Enrollment with the selected MCOs will start January 1, 2016. The program will enroll most of the Iowa Medicaid and CHIP populations and will also manage certain services for individuals meeting eligibility criteria for IDPH-funded SUD treatment. Selected MCO contractors will provide all physical and behavioral health services through a single Medicaid managed care structure. This delivery system change is designed to further integrate physical and behavioral health services and strengthen coordination across a broader range of medical and social services and supports, ensuring greater attention to coordinated person-centered care. Similar to the current construct, IDPH, IME, and MHDS will continue to collaborate to ensure coordinated care and improved outcomes for Iowans.

Specifically, the two behavioral health authorities will work with IME and the selected MCOs to implement and monitor service access and quality outcomes against contract requirements and state goals.

Moving from a behavioral health carve-out model to carving behavioral health services into a comprehensive and integrated managed care structure is part of a statewide vision for increasing pay-for-performance, and other system transformation including SIM, ACOs, and value based purchasing. The new delivery system presents opportunities that Iowa can explore using the CCBHC opportunity.

A-2. Prevalence rates in Iowa

In Mental Health America’s 2015 report, “Parity of Disparity: The State of Mental Health in America,” Iowa ranked 12th nationally in an overall ranking of statewide mental health. The ranking suggests that Iowa has a lower prevalence of mental illness and higher rates of access to care than the majority of states across the country. The report is careful to qualify this ranking with the caveat that a high ranking does not mean a state is “doing well,” only that a state is doing relatively better on a specific measure or set of measures. An examination of the specific measures in the report brings home that point. Although Iowa is ranked 5th nationally in the Access ranking, suggesting relatively better access to care, it also ranks 28th nationally in the Need ranking, suggesting a higher prevalence of MH needs for the state’s citizens. This assessment is confirmed in SAMHSA’s 2014 State Behavioral Health Barometer, where the MH prevalence rates in Iowa are somewhat higher than the national average.

The SAMHSA 2014 State Behavioral Health Barometer for Iowa shows Iowa prevalence rates for use of specific substances compared to the national average. Notably, Iowa has higher rates of heavy alcohol use for both youth and adults. These metrics are included the table below.

<i>Metric:</i>	<i>Iowa:</i>	<i>United States:</i>
<i>Mental Health</i>		
Past-Year Major Depressive Episode (MDE) Among Adolescents, ages 12-17	10%	9.9%
Past-Year Serious Thoughts of Suicide among Adults, aged 18 or Older	4.2%	3.9%
Past-Year Serious Mental Illness (SMI) among Adults aged 18 or Older	4.4%	4.1%
Children identified as having a serious emotional disturbance (SED)	1.3% **estimated	.8%
<i>Substance Use</i>		
Cigarette Use among Adolescents	7.2%	6.1%
Past Month Binge Alcohol Use Among People Ages 12-20	16.6%	14.7%
Past-Month Heavy Alcohol Use among Adults aged 21 or Older	8.2%	6.8%

In Iowa 18.4% of adults aged 18 and over had Any Mental Illness (AMI) in the Past Year, as compared to 18.2% for the United States (Source: SAMHSA (2014) The NSDUH Report).

One of Iowa’s CCBHC subpopulations of focus is veterans. There are 231,655 veterans in Iowa according to the Department of Veterans Affairs, Office of the Actuary, Population Projection Model, 2014. With a total Iowa population of 3.11 million (U.S. Census Bureau), veterans comprise 7.4% of Iowa’s population. While Iowa does not have specific prevalence data for MH and SUD needs or services among the state’s veterans, Iowa can build on IDPH’s Iowa National Guard/Service Members/Veterans/Families Policy Academy and subsequent Access to Recovery

(ATR) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) experiences and extrapolate from national data to draw conclusions about the needs of Iowa's veteran population. According to the American Psychological Association, veterans experience a number of behavioral health disparities. Specifically:

- Suicide rates increasing for returning service members. Preliminary data from the VA shows that the suicide rate for 18-29-year-old male veterans who have left the military rose 26% from 2005 to 2007, and the rate climbed to record highs by 2009 (2010).
- Unemployment rate for veterans outpaces the civilian rate. Recent veterans are more likely to be unemployed than their civilian counterparts. According to data released by the Bureau of Labor Statistics in October 2011, veterans who left military service in the past decade have an unemployment rate of 11.7%, well above the overall jobless rate of 9.1% (M. Fletcher, *Washington Post*, Oct. 16, 2011).
- Veterans are returning with serious mental health issues. Of the 1.7 million veterans who served in Iraq and Afghanistan, 300,000 (20%) suffer from post-traumatic stress disorder or major depression (RAND Center for Military Health Policy Research, *Invisible Wounds of War*, 2008). The Department of Veterans Affairs also estimates that nearly 13,000 of Iraq and Afghanistan veterans have alcohol dependence syndrome (2009). In a survey of all veterans, 7.1% (1.8 million people) meet criteria for a substance abuse disorder (Substance Abuse and Mental Health Services Administration, *2004-2006 National Survey on Drug Use and Health*, 2007).
- Many in need don't seek help. According to the Army, only 40% of veterans who screen positive for serious emotional problems seek help from a mental health professional (*Mental Health Advisory Team IV: Operation Iraqi Freedom*, 2007). Statistics from the RAND Corporation are even worse, finding that only 30% of veterans with PTSD or depression seek help from the VA health system (*Invisible Wounds of War*, 2008).

In 2010, recognizing the behavioral health challenges of veterans, the Iowa Department of Veterans Affairs and the Iowa Commission of Veterans Affairs convened the Iowa Veterans Mental Health Task Force to identify critical issues and barriers within the veterans' mental health and substance abuse systems and to develop recommendations to improve behavioral health services to Iowa veterans. The Task Force identified six priority issues. The issues include stigma; communication, awareness, and outreach; screening; access; relationships with and continuity of providers; and a culture of support. CCBHC provides an opportunity to engage the Iowa Department of Veterans Affairs and the Iowa Commission of Veterans Affairs in addressing these issues as part of CCBHC development and monitoring.

Another subpopulation of focus is American Indian/Alaskan Native (AI/AN). The data below provides demographic data on Iowa's AI/AN population (Source: State Data Center of Iowa. (2015). Native Americans in Iowa: 2015).

- Iowa had 14,742 American Indians and Alaska Natives living in the state in 2013, 9.9% of whom were under the age of 5 years old (compared to 6.6% for the state as a whole).
 - The median age of Iowa's AI/AN population is 29.7 years (compared to 38.1 for Iowa as a whole)
 - The majority (18.3%) of Iowa's AI/AN individuals live in Woodbury County, followed by Polk (12.8%) and Tama (9.2%).

- 67.8% of Iowa's AI/AN population lives in an urban area (compared to 58.5% of the rest of the state)
- 686 of Iowa's AI/AN individuals are veterans of the US Armed Forces.
- 33.2% of Iowa's AI/AN families were living in poverty in 2013 (compared to 12.7% of the state's families overall).
- 19.1% of Iowa's AI/AN individuals have a disability (compared to 11.7% of Iowans overall).

The specific geographic locations of CCBHC will be determined during the planning year, at which point Iowa will better understand prevalence rates in CCBHC regions.

A-3. Capacity of the current Iowa Medicaid State Plan to provide CCBHC services

Iowa's Medicaid State Plan specifies coverage and limitations for Medicaid-covered behavioral health services. Iowa offers a comprehensive benefit package for the treatment of mental illness and SUDs. The behavioral health benefit package demonstrates Iowa's commitment to ensuring Iowans live healthy and safe lives and achieve personal recovery through highly integrated and coordinated services and systems. By developing CCBHCs on the existing infrastructure available in the state (i.e., accredited and licensed behavioral health providers, integrated health homes), individuals seeking care in Iowa will have timely access to appropriate levels of service, better integrated and coordinated services, and delivery designed to ensure their active participation in the planning and evaluation of their care.

In development of the CCBHC Planning Grant application, Iowa behavioral health leadership developed a crosswalk to compare MH and SUD services and infrastructure currently provided under the Medicaid State Plan with the CCBHC requirements identified in Appendix II of the RFA. All nine of the services required of CCBHCs are currently available across Iowa, although availability varies among providers and regions of the state. Iowa will utilize the CCBHC Planning Grant as an opportunity to improve service accessibility and extend the capacity of the existing provider network to address key population needs identified by the state. For example, in its analysis of current infrastructure versus CCBHC requirements, the state identified opportunities to improve access to essential services, including psychiatric rehabilitation and assertive community treatment (ACT).

Iowa's Medicaid State Plan documents and companion state regulations detail the extensive MH and SUD service array available in the state. Currently covered Medicaid State Plan MH services include, but are not limited to: 24-hour crisis and emergency services, outpatient services, consumer-run services, warm line and peer support, MH services through a community mental health center, in-home services, integrated MH services and supports, and assessments and evaluations. Covered Medicaid State Plan SUD services include, but are not limited to: assessment and evaluation, detoxification, outpatient, intensive outpatient, multiple levels of residential treatment, inpatient, 24-hour helpline, and treatment locator services.

Iowa continues to demonstrate a commitment to care coordination, the lynchpin of the CCBHC initiative, through its statewide implementation of IHHs for Iowans with an SMI or an SED. The expansion of the full continuum of CCBHC services into the existing service array will

complement Iowa's efforts of improving outcomes for Iowans with mental illness or SUD through comprehensive care coordination efforts.

A preliminary review of Iowa's current behavioral health system revealed that many of the services and service delivery requirements are present in some way, shape or form throughout the state. However, currently there is no standardized statewide approach that requires the nine services to all be provided by a single entity and there are inconsistencies in access and availability.

During the planning year, as Iowa works with candidate CCBHCs, assessment of the alignment of the current system with the CCBHC requirements will continue to ensure that identified gaps are resolved as part of the certification process and implementation.

In addition to compliance with the CCBHC requirements, Iowa plans to leverage the CCBHC opportunity to identify opportunities to standardize requirements across agencies and promote development of consistent requirements for clinics, services, payment, and performance outcomes.

A-4. Nature of the problem in Iowa

Over the past several years, Iowa has been organizing its public behavioral health system to focus on improved quality and outcomes, and better bi-directional integration of behavioral health and medical services. The CCBHC Planning and Demonstration Grants are an opportunity to accelerate progress on these efforts.

Providers and other stakeholders involved with the behavioral health improvement effort in the state are intent on continuing improvement and building on historical initiatives such as NIATx, (Network for the Improvement of Addictions Treatment) and particularly on current initiatives such as IHH, the SIM testing grant, the addictions service system transition, and the Iowa Health and Wellness Program. Many providers across the state are well positioned philosophically and logistically to achieve the CCBHC certification and are motivated and prepared to advance their service delivery capacity through the CCBHC opportunity.

In an effort to raise the bar for standardization and quality in behavioral health services, Iowa will use the Planning Grant as an opportunity to align and improve coordination of its service delivery system. The challenges Iowa seeks to overcome include:

- Insufficient integration of MH and SUD services.
- Inconsistent use of and proficiency in evidence-based practices, especially for Iowans with an SMI or an SED.
- Insufficient proficiency in delivery of integrated physical and behavioral health care.
- Inefficient service access and delivery processes.
- Undesirable variations in the service delivery system, particularly between rural and urban communities.
- Lack of access to crisis stabilization services and the full array of community-based services in the community.
- Inconsistent service array across MH and SUD services.

- Lack of standardized processes and policies for services coverage, performance expectations, and provider monitoring and oversight.
- Shortage of behavioral health professionals. The workforce shortage of behavioral health professionals, especially those able to prescribe medications is a national crisis with over half of the US counties having some unmet need (Konrad et al, Psych Services, 60:1307-14, 2009). Iowa is an extreme example of this national problem. Iowa ranks 47th out of 50 states in the number of psychiatrists per capita which is half the national average. Complicating the problem of workforce number is the disproportionate geographical distribution of the existing providers; over half the existing psychiatrists practice in just two Iowa counties. The aging of the current workforce adds another recruitment strategy need. These workforce trends driven by increased service demand are exemplified by other behavioral health professional groups, such as psychologists and social workers.

In addition to addressing these infrastructure and system problems, Iowa has identified challenges that will be considered during the CCBHC planning year.

- ACT Access: Currently, there are five providers of assertive community treatment (ACT) services in Iowa. Four of these providers are in large urban areas. Based on nationally used models, Iowa should have at least 15 ACT teams.
- Psychiatric Rehabilitation Access: Currently psychiatric rehabilitative services are not a mandatory service required to be provided by CMHCs or MHSPs. Rates of access to psychiatric rehabilitation, relative to the population diagnostically eligible to receive the services, are low.
- SMI Outcomes: The prevalence of SMI in Iowa is similar to the national average. In Iowa about 107,000 adults aged 18 or older had SMI within the year prior to the survey. However the percentage of Iowans reporting improved functioning from treatment in the public mental health system is lower than the nation as a whole. Iowa will explore new evidence-based practices that have a demonstrated impact on the lives of individuals with SMI. They are listed in section B-5 below.
- Opiate and Synthetic Opioid Use: Larger counties in the state have experienced a significant increase in the use of opiates including heroin and synthetic opioids. These counties include: in the central area, Polk (Iowa's most populous), Story and Jasper; in the Northwest area, Woodbury; and in the Southeast area, Johnson and Scott. Admission data document a 152% increase in Iowa's opiate-using population. Opiate-related deaths, a majority from prescription drugs, have also significantly increased. Between 2009 and 2013, 594 Iowans overdosed due to opiates.
- In Iowa, about 178,000 adults aged 21 or older reported heavy alcohol use within the month prior to being surveyed. SAMHSA reports that Iowa's percentage (8.2%) is higher than the national percentage (6.8%).

According to SAMHSA-HRSA, 50% of persons with behavioral health disorders smoke, compared with 23% of the general population. Persons with mental health and substance use conditions smoke half of all cigarettes produced, but are only half as likely as other smokers to quit, even though cessation has been positively associated with general health and recovery. Smoking-related illnesses cause half of all deaths of persons with behavioral health disorders. Further, 30-35% of the behavioral health workforce smokes. These rates are believed to hold true for Iowa residents.

Section B: Proposed Approach

B-1. Expanding capacity, access and availability of services in Iowa

Consumer-driven recovery from behavioral health disorders is a primary goal for Iowa's public system. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Iowa will use the SAMHSA Recovery Support Strategic Initiative as a cornerstone of its CCBHC planning grant and demonstration project, by focusing efforts on the four major dimensions of recovery: health, home, purpose, and community.

Iowa identifies the CCBHC population of focus as: adults with an SMI, children with an SED, adults with long-term SUDs, and any other individuals seeking MH and SUD services. While Iowa has an extensive Medicaid-funded MH and SUD treatment and delivery system, the state seeks to improve accessibility to needed services, strengthen the capacity of clinics to deliver more integrated and coordinated care, extend the availability and use of evidence-based practices (EBPs) in rural and underserved areas, and ensure more timely access to needed services. The state will maximize opportunities during the planning year to address these and other factors identified in A.4. Iowa will establish a framework to successfully administer the CCBHC Demonstration Grant and to prepare the provider community to improve health outcomes, processes of care, quality of care, and consumer satisfaction.

Iowa has an established structure, accreditation and licensure processes, and other monitoring protocols in place to ensure that existing services meet required standards and can be accessed by Iowans in need of MH/SUD prevention and treatment. Planning Grant funds offer the state an opportunity to augment Iowa's capacity to offer specialized supports to clinics, especially with regard to the effective integration of MH/SUD services, behavioral health, and primary care services. Iowa intends to establish a state-level CCBHC Leadership Committee that will establish subcommittees and work groups charged with promoting a culture of continuous improvement in CCBHCs.

DHS and IDPH will utilize Planning Grant funds to develop a multi-stakeholder approach to assess provider readiness and identify training needs, develop and deploy training resources, identify providers' data and reporting capacity, develop protocols for data reporting and submission, and offer technical assistance.

Specific areas that Iowa identified through its preliminary CCBHC gap analysis that will be a focus for outreach, training and technical assistance include, but are not limited to:

- Motivational Interviewing, Trauma-Focused Cognitive Behavioral Therapy, suicide prevention, and Feedback Informed Treatment.
- Enhanced services for veterans, and education on military cultural competency using the online continuing education course, Military Culture: Core Competencies for Health Care Professionals.
- Client engagement techniques for underserved populations (e.g. veterans).
- Workforce strategic planning and development, both professional and peer support.
- Development of ACT programs in rural settings.

- Identification and implementation of EBPs for psychiatric rehabilitation that meet established fidelity standards.
- Health education and prevention activities designed to reduce tobacco usage, binge alcohol use, and address cultural attitudes about alcohol.

B-2. Stakeholder engagement processes during development of the demonstration program

Iowa values stakeholder engagement in the development of new initiatives and as such will create a multi-dimensional approach to involving various stakeholders in the CCBHC initiative.

The core principles for the CCBHC Stakeholder Engagement process are:

- Engage individuals, families and other support systems to actively participate in the planning and demonstration of CCBHCs and subsequent treatment planning and development of successful behavioral health interventions.
- Support and emphasize standardization of the basic components of behavioral health services.
- Improve methods for comprehensive stakeholder education.
- Encourage aggressive engagement to ensure an adequate understanding of CCBHC and to promote a collaborative effort to enhance the delivery of high quality behavioral health services.
- Facilitate participation of stakeholders via various media and venues.
- Ensure input from stakeholders through provision of transportation, interpretation services, and personal care assistance.
- Publicize methods and opportunities for stakeholder input.

There are three primary strategies that will be implemented through these principles. First, a core CCBHC Stakeholder Advisory Group will be convened that will act as a consistent and representative body with which the CCBHC Project Governance team, comprised of leadership from the partner agencies, will share information, engage in planning, vet ideas, and resolve issues. The CCBHC Stakeholder Advisory Group will include, but not be limited to: DHS and IDPH CCBHC Project Governance Team representatives, individuals with lived experience, families of individuals with lived experience, service providers, MHDS Regional CEOs, local funding entities, and service advocates. Advocates, consumers, and families will provide critical input on topics such as service delivery, quality of care, rights and responsibilities, education, and identification of areas that require improvement. Provider input will be representation of entities that interact with behavioral health consumers in the state, including community-based providers, hospital systems, primary care, and behavioral health. Consumers and families will be representative of diverse subpopulations identified for prioritization under this CCBHC initiative (i.e., veterans, youth, American Indians/Tribal Communities).

Second, CCBHC Project Governance Team members will participate in other advisory groups with similar or overlapping duties. Such groups include: Criminal and Juvenile Justice Planning, the Department of Corrections re-entry work group, the Drug Abuse Policy Advisory Council, Drug Court Advisory groups, the OWI advisory group, Medical Assistance Advisory Council, provider association meetings, and the Partnerships for Success underage/binge drinking advisory council. This list will grow and evolve as progress is made during the Planning and Demonstration years.

Third, information about CCBHC, and opportunities to obtain feedback, will be included in other stakeholder engagement processes conducted, supported, or governed by DHS and IDPH. Examples of these processes include: Iowa Mental Health and Disability Services Commission; MHDS Regional Leadership Meeting; the Medicaid pregnant women's group; Iowa Mental Health Planning Council; State Board of Health/Program Licensure Committee; Olmstead Consumer Task Force; IDPH SAPT Block Grant input processes including "listening posts" held on-site at provider locations; "A Matter of Substance" monthly newsletter distributed to all licensed SUD programs, contractors, and other stakeholders; Iowa Plan advisory group meetings and client and family satisfaction surveys; meetings with Iowa's counselor certification organization; and the IDPH Outcome Management System client follow-up process.

During the planning year, Iowa's newly selected Medicaid managed care organizations will be engaged with the purpose and goals of the CCBHC initiative. While the MCOs have not yet been selected, the procurement process and resultant contracts will clearly articulate requirements to support related state initiatives. Iowa's impending transition to a more comprehensive and integrated Medicaid managed care plan effective January 1, 2016 will require MCO involvement in CCBHC planning which will be critical to successful whole-person treatment.

B-3. Selection process and support for community behavioral health clinics

Iowa will engage existing behavioral health and related service providers in the CCBHC selection process. Iowa's Integrated Health Home (IHH) model is a practice of focus in considering provider capacity to function as a CCBHC. Health disparities and social factors are driving change in the healthcare system. Implementation of IHH is a transformational change that emphasizes integration of physical and behavioral care, and requires innovative new approaches to healthcare overall. IHH is also the modality by which targeted case management to adults with an SMI and children with an SED is delivered. In Iowa, IHH has been designed to engage community-based MH and SUD providers as health homes. CCBHC is the next logical step to build upon this initiative.

To determine a behavioral health provider's capacity to successfully carry out CCBHC program requirements, all interested providers will be required to complete the *readiness assessment* distributed by the National Council (included in Attachment 2 of this application). The results of those assessments, combined with stakeholder input and existing knowledge and experience of MH/SUD and providers' experiences in achieving and maintaining licensure and certification, will help the state understand where to further focus attention, potentially narrowing the number of CCBHC candidates, and helping refine plans for technical assistance and support. Additional considerations we will use to narrow selection criteria include:

- Geography – to ensure both an urban and rural CCBHC.
- Service array of CMHCs, MHSPs and SUD providers, and the extent clinics will have to rely on designating collaborating organizations.
- Use of fidelity compliant EBPs.
- Understanding the unmet needs of populations (including subpopulations).
- Capacity to report costs associated with development of the PPS.

Following evaluation of the readiness assessment, Iowa will develop and implement a technical assistance (TA) program. A centralized training/TA effort offered through the Planning Grant is the most practical and consistent method of assuring training and TA are offered to all interested providers. Iowa will work with each of the selected MCOs to ensure alignment of the CCBHC TA efforts statewide.

In keeping with the goal to evolve the entire system, some of the TA included in the program will be low-touch, available to all interested CMHCs, MHSPs and SUD providers. Iowa will use Planning Grant funds to establish a series of learning communities in which potential CCBHCs, particularly those in rural and other underserved areas, will participate and receive support on developing capacity to comply with CCBC certification standards, particularly to ensure the expansion of capacity, access and availability of EBPs. Iowa will finalize curriculum and faculty based on the results of the readiness assessment. Iowa will also provide support to participating agencies that minimizes financial hardship to potential CCBHC providers while supporting staff involvement in EBP training and TA.

However, at this stage there should be a narrowed field of candidate CCBHCs. More high-touch individual TA and training designed to help a specific candidate achieve the CCBHC standards, resolving any workforce, staffing, service array or access issues including DCO contracting or data and reporting capability issues, and addressing candidate-specific training needs will be addressed and offered within available resources of the grant or other technical assistance resources available to the state.

A Request for Applicants (RFA) will be issued requiring applicants to document their current capacity relative to the CCBHC requirements, and to commit to maintaining capacity where the requirements are met and achieving capacity within specified timelines where they fall short. IHH implementation required development of a model, and then providing training, managing data, providing tools for IHH provider use in managing and sharing health information, developing and maintaining a statewide network of providers, performing regular performance evaluation, and providing care coordination. Iowa will administer the planning grant using all the lessons learned from IHH as well as adopting appropriate tools and processes such as those used to implement IHH.

Introducing CCBHCs using similar change and transition methods will minimize undesirable disruption to the current behavioral health delivery system and make a smooth and transparent transition to the next level of encouraging the treatment of the whole person.

B-4. Service provision by CCBHCs in Iowa

All CCBHCs will provide required core services and standards; however, based on the unique needs of certain regions of the state where each ultimate CCBHC is located, there may be additional practices provided by some of the clinics.

The core services and standards will be derived from Appendix II and Iowa's licensure and accreditation requirements. These core services include:

- The nine required CCBHC services, four of which must be delivered directly and five of which can be delivered directly or via a DCO.

- Care Coordination to organize patient care activities and share information among all of the participants concerned with a patient’s care. Care coordination and targeted case management are expected to be provided through the IHH model of team-based care coordination.
- Data collection and reporting.
- Use of a CCBHC Treatment Team in concert with the care coordination team

The services and standards that may vary by CCBHC include:

- Staffing requirements – in addition to core staffing requirements, these will be CCBHC-specific staffing requirements based on the consumer population of the CCBHC, taking into consideration cultural and linguistic needs, geography, and population demographics.
- Care coordination contracts – in addition to requirements for CCBHCs to establish care coordination contracts with named entities, the CCBHCs will identify community specific service and support providers with which to execute formal care coordination contracts.
- Health information technology – all CCBHCs will be required to have the capability to meet requirements, but have flexibility in how they do so.
- Continuous Quality Improvement (CQI) Plan – each CCBHC must have a CQI Plan for clinical services and clinical management. The CCBHC must submit its CQI plan for state approval during certification, and each CCBHC’s CQI Plan will be unique and specific to that clinic.

The RFA process to become a CCBHC will result in documentation of a CCBHC’s agreement to provide core services and meet core standards, and will document CCBHC-specific services and standards based on the unique population and community of the CCBHC. Iowa will augment oversight procedures to ensure appropriate monitoring of the CCBHC-specific services and standards.

B-5. Evidence-Based Practices and Selection Criteria

Implementation of specified EBPs will allow Iowa to assure standardization of care in CCBHCs and expand access to a broader range of EBPs. This is consistent with the goals of Iowa’s Mental Health Redesign legislation which mandates that MH and disability service regions provide access to specified core services, and that individuals have access to services for co-occurring conditions, evidence-based services, and trauma-informed care. The purpose of this legislation was to establish statewide access to consistent services and to reduce the disparity that currently exists among counties regarding the type and quantity of mental health and disability services available. This approach is also consistent with IDPH’s addictions service system transition.

The 2015 Iowa General Assembly enacted House File 630 which mandates that CMHCs receiving mental health block grant funds use the funds for staff training and direct services to individuals. CMHCs are familiar with the process used by DHS MHDS to select EBPs. IDPH also promotes and funds EBP adoption by its licensed programs and contractors.

For CCBHCs, Iowa will continue to use a process modeled after SAMHSA’s revised guidance for “Identifying and Selecting Evidence-Based Interventions.” The process calls for assessing population needs and identifying resources to address the problem; building capacity at state and

community levels to address needs and problems identified; developing a comprehensive strategic plan; implanting evidence-based programs, practices, and policies; monitoring implementations, evaluating effectiveness, sustaining effective activities, and improving/replacing practices with less than desired results. Iowa and its current behavioral health MCO partner have used this process to introduce a number of EBPs in the state's MH/SUD delivery system.

Iowa has identified a set of EBPs that will be discussed with stakeholders before becoming required CCBHC EBPs:

- Assertive Community Treatment (ACT) – Iowa currently has five ACT providers, primarily located in urban areas of Iowa. MHDS believes that at least 10 more ACT teams are needed in the state, as supported by the December 2014 report of the Community Integration workgroup.
- Several of Iowa's MHDS regions are working with University of Iowa ACT experts toward development of ACT teams to serve persons living in rural areas. The CCBHC grant is an opportunity to coordinate efforts to bring intensive community-based services to rural areas not currently served by an ACT team and to coordinate with MHDS regions on the ongoing funding and support of the ACT service for both Medicaid and non-Medicaid eligible individuals.
- Feedback Informed Treatment (FIT) – IDPH is exploring introducing FIT statewide. The CCBHC planning year provides an opportunity to provide additional FIT training. FIT is an empirically supported, pan-theoretical approach for evaluating and improving the quality and effectiveness of behavior health services. It involves routinely and formally soliciting feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. FIT is included in the NREPP.
- Medication Assisted Treatment (MAT) – Approximately one-third of licensed SUD programs currently provide MAT services. Iowa plans to expand MAT services, increase the number of individuals receiving MAT services, and decrease illicit drug use.
- Motivational Interviewing (MI) – IDPH has historically provided MI training to SUD provider staff. During the planning year, Iowa will provide education to individuals not currently trained in MI. MI is an NREPP treatment approach recommended for its effectiveness with people with substance use and co-occurring mental health disorders. MI is particularly helpful in assessment and early intervention and in engaging clients over time. The principles of MI are consistent with strongly held values of recovery, cultural competency and patient self-determination.
- Psychiatric Rehabilitation – During the CCBHC Planning Year, Iowa proposes to determine the best practice for provision of psychiatric rehabilitation. Eight providers in Iowa currently provide Intensive Psychiatric Rehabilitation using the Boston University model. A different model of psychiatric rehabilitation is listed in the NREPP. Iowa prefers to use existing provider capacity wherever possible while following requirements to provide an evidence-based practice.
- Tobacco Cessation – Iowa will disseminate the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers SUPPLEMENT Priority Populations: Behavioral Health (University of Colorado) and EX - re-learn life without cigarettes (National Alliance for Tobacco Cessation and Mayo Clinic) as promising practices for reducing tobacco use.

- Tobacco Quitline/NRT – The IDPH Division of Tobacco Use Prevention and Control sponsors and funds Iowa’s Tobacco Quitline and related Nicotine Replacement Therapy. During the planning year, Iowa will educate all mental health and substance use disorder providers on the AAR – Ask, Advise, and Refer – approach to initiating smoking cessation and on the availability of free Quitline services.
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) – Iowa stakeholders have been strong supporters of dissemination of national research on Adverse Childhood Experiences (ACES) as risk factors for negative outcomes such as increased risk for substance use, mental illness, and physical illness. Providing children with a trauma history with a trauma-specific evidence-based intervention will help mitigate longer term effects of childhood traumatic experiences.

These EBPs were selected in part based on their demonstrated effectiveness for diverse populations and potential for implementation in both rural and urban areas.

Iowa providers also have capacity to provide a wide array of EBPs beyond those chosen as targeted practices for the purposes of the grant. EBPs and best practices that have been supported and funded through the Mental Health Block Grant include: peer support services, trauma-informed care, co-occurring/multi-occurring capability, Mental Health First Aid (MHFA), Parent Child Interaction Therapy (PCIT), WRAP services, Motivational Interviewing, Cognitive Behavioral Therapy (CBT), School-Based Mental Health, Eye Movement Desensitization and Reprocessing (EMDR), Suicide Prevention, Supported Employment, Dialectical Behavior Therapy (DBT), Illness Management and Recovery (IMR), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

EBPs and best practices that have been supported and funded through the Substance Abuse Prevention and Treatment Block Grant and related grants and funding include: Access to Recovery and recovery peer coaching, trauma-informed care, bi-directional integration of SUD and medical/MH services, MHFA, Multi-Dimensional Family Therapy, NIATx, Strengthening Families/Celebrating Families, SBIRT, and suicide prevention.

Iowa has also identified a need for standardization of practices for monitoring of fidelity for EBPs. Iowa plans to obtain technical assistance and support in developing standardized methodology for measurement of EBPs across funding and administrative systems.

B-6. Iowa certification of CCBHCs in urban and rural areas

During the planning year, Iowa will finalize a CCBHC Certification Process in consultation with the CCBHC Stakeholder Advisory Group, and use the process to certify at least two CCBHCs, with at least one rural and one urban.

Iowa will identify candidate CCBHCs based on the readiness assessment, and envision developing a formal RFA for moving from candidate to actual CCBHC. The RFA will require applicants to document their current capacity relative to the CCBHC requirements in the RFA, and commit to maintaining capacity where the requirements are met, and achieving capacity within specified timelines in areas where they fall short.

While the plan is to certify at least two clinics, Iowa has tentatively established a maximum of four to be certified during the planning year. That number could change with additional stakeholder input, or based on the outcome of the readiness assessments. The RFA will minimally:

- Specify the intent to certify at least two CCBHCs, one rural and one urban.
- Require adherence to all current applicable federal, state and local accreditation and licensure regulations.
- Require documentation of capacity and commitment.
- Outline the process for evaluation of applications resulting from the RFA.
- Describe the planned certification process for successful applicants.
- Outline the anticipated readiness and implementation processes when Iowa is selected as a demonstration state, and require participation by CCBHCs.

Based upon the existence of current licensure and regulatory resources already being deployed, Iowa is confident in its ability to meet the program requirements for provider credentialing, licensure, and certification required for CCBHCs. Therefore, Iowa plans to develop a new accreditation/licensure criteria for CCBHC, building on the requirements in code and administrative rule for CMHC, mental health service provider, and licensed providers of outpatient substance use disorder services. It is expected that a CCBHC would have the capacity to meet Iowa Administrative Code (IAC) Chapter 24 accreditation standards for a CMHC or equivalent mental health service provider which would include accreditation for each of the individual services required to be directly provided by a CCBHC and included in Chapter 24, IDPH licensure for outpatient SUD services, IAC Chapter 90 standards for targeted case management (provided through the IHH model) if the CCBHC provides the service directly, plus additional accreditation standards for any CCBHC direct-provided services not included in the accreditation and licensure standards referenced above. Any clinic seeking certification as a CCBHC must also meet the criteria for services to Veterans and armed forces members, as described in Criteria 4.k of the RFA.

As a byproduct of developing the RFA, Iowa may identify other CCBHC criteria that are needed or could be added to existing accreditation or licensure requirements. Similarly, Iowa will evaluate our MH/SUD program monitoring and oversight processes to ensure that they comply with the requirements in Appendix II.

Once clinics are formally selected and certified as CCBHCs, they will be instrumental in implementation planning, and transition to the demonstration operations and evaluation. Iowa will continue to work closely with CCBHCs during the transition process and will contract for and provide technical assistance on the transformation efforts, business and clinical, that will need to occur for a provider to successfully meet the CCBHC standards.

B-7. Final planning activities for transition to implementation of the demonstration program

Similar to other large-scale system reform efforts undertaken by the state (e.g. Integrated Health Homes, State Innovation Model), Iowa will develop a multi-agency operational planning framework and structure so that the state, potential CCBHCs, external healthcare partners essential to CCBHC's success (e.g., hospitals, FQHCs, likely designated collaborating

organizations, etc.); and community stakeholders are prepared to advance the CCBHC through different phases.

The first formal phase is the planning process to begin immediately upon notification of award of Planning Grant funds. Upon submission of the CCBHC Planning Grant application, Iowa will transition into pre-Planning Phase mode to begin identifying, prioritizing, scheduling and resourcing activities necessary to successfully complete the objectives of the one-year planning grant period (e.g., stakeholder input process, rules/policies for CCBHC certification, development and CMS approval of the preferred PPS option, CCBHC readiness assessment and subsequent certification of CCBHCs, etc.). These activities will be documented in a project plan.

Immediately upon notification of the grant award, and start of the formal first phase, Iowa will implement a staffing plan and secure internal and external human and other resources as necessary to fulfill the commitment of a CCBHC grantee state. Specifically, Iowa will establish an internal governance process that clarifies the roles and responsibilities of personnel identified in Section C: Staff, Management, and Relevant Experience.

During the planning year, the CCBHC Project Director will oversee finalization of the CCBHC project plan, and execution of the activities laid out in the plan. The project plan will be a living document, allowing the addition of tasks, or the elaboration of tasks to allow better tracking, monitoring, and status reporting. The Project Governance Team will work with the selected CCBHCs to develop an implementation plan that anticipates the tasks, and processes required to move from the planning year to implementation and operations. Having a detailed implementation plan will allow Iowa to move quickly from planning to implementation. The CCBHC timeline currently anticipates that Demonstration Grant applications are due October 31, 2016 with the two-year demonstration starting on January 1, 2017. That suggests a three-month window for SAMHSA to select eight states from the applicants, notify those states, and for those states to implement.

To be successful, Iowa will complete as much as feasible during the planning period, reserving only the final implementation tasks to be conducted upon notice of our selection as a demonstration state. Iowa anticipates that the final implementation tasks will focus heavily on CCBHC readiness assessment, technical implementation and cutover to PPS, communications to keep stakeholders apprised of status, and issue and risk management.

B-8. PPS selection and base cost data collection

Iowa will develop a payment system for CCBHCs following the Certified Clinic Prospective Payment System 1 (CC PPS-1) model. We have reviewed the two PPS methodologies and determined that PPS-1 is the most appropriate for Iowa at this time. Iowa is in the process of converting the Medicaid system to managed care, effective January 1, 2016. Use of PPS-1 is consistent with current PPS methodology for FQHC, which will continue under managed care. CMHC providers are familiar with the type of cost-reporting that would be required of a CCBHC. PPS-1 also presents the greatest opportunity of aligning with value-based purchasing and ACOs.

As specified in Appendix III, cost and visit data will be collected in the planning grant period. Iowa expects to use one full year of cost and visit data. If additional data about actual experience is required for an actuarially sound approach to PPS rate development, Iowa will either augment data collected within the planning grant period with similar data for the potential CCBHC entity from an earlier period of time (not to exceed 24 month prior to the beginning of the planning grant period, or request that CMS approve the use of data from a shorter period of time -not less than 6 months) for informing the establishment of base cost for Demonstration year 1, or an alternative approach to be determined working with CMS.

Supporting data will be collected to substantiate cost and visit data from potential CCBHCs and their related potential DCOs. Where available, Iowa will use and/or, modify uniform current cost reports used by these providers or similar providers in Iowa. Iowa will use the Medicare Economic Index (MEI) to inflate cost data collected during the planning grant period for Demonstration Year 1 PPS-1. Iowa anticipates rebasing to inflate PPS-1 rates from Demonstration Year 1 to Demonstration Year 2.

Base cost data will include total annual actual allowable CCBHC cost, including related DCO cost, and estimated cost related to services or items not incurred during the planning phase but projected to be incurred during the demonstration.

Because Iowa will implement CC PPS-1, daily visits reported will be the total number of CCBHC daily visits per year. This number will include DCO encounters. Visit data for establishing PPS-1 for potential CCBHCs will include visit data collected in the planning grant period, and if Iowa uses cost data from time periods other than the full 12 months of the planning grant period, visit data that aligns with the modified cost data period will be collected. Iowa will not be implementing the optional Quality Bonus Payment provided for in PPS-1.

To ensure compliance with CCBHC reimbursement criteria, Iowa proposes to contract for expertise in assisting potential CCBHC providers to develop cost reports and fully understand and comply with the requirements of the prospective payment system. This contract will also provide support and technical assistance to DHS for development of the PPS system required for CCBHC services.

B.9. Describe how the state will establish a PPS for behavioral health services provided by CCBHCs in accordance with CMS guidance in Appendix III.

Iowa will use CC PPS-1 for CCBHC payment. This daily rate structure is selected understanding that it is a fixed amount for all CCBHC services provided on a given day to a Medicaid beneficiary. Iowa will use cost and visit data collected as reported above in B.8 for the PPS-1 rate in Demonstration Year 1, including estimated data to reflect service and other modification required for the CCBHC to comply with CCBHC certification and program requirements, updated by the MEI to create the rate for DY1. We will update the DY1 rate for DY2 by rebasing. To establish the daily rate total annual allowable CCBHC cost will be divided by the total number of CCBHC daily visits per year, including associated DCO cost and encounters.

During the planning year, IME and MHDS will discuss how to best incorporate the CCBHC rate into the managed care payment methodology. Iowa will also examine how to identify

productivity rates of CCBHC practitioners into the reporting system. Iowa will ensure that the CCBHC rate established through the managed care entity does not duplicate payment for services already included in the managed care capitation rate and will include requirements in managed care contracts regarding access to, and payment of, CCBHC services. To support the calculation of the PPS for DY-1, Iowa will identify allowable costs necessary to support the provision of CCBHC services using a uniform cost report demonstration wide that adheres to 45CFR 75 Uniform Administrative Requirements, Cost Principles and Audit Requirement for HHS awards and 42 CFR 413 Principle of Reasonable Cost Reimbursement and any provisions specific to the CCBHCs Planning Grants as specified in RFA No. SM-16-001. Iowa has proper fiscal controls and accounting procedures in place to permit tracing of funds to a level of expenditures adequate to establish that funds are not used in violation of applicable statutes. Iowa’s uniform cost report package and source documentations adhere to federal and state record retention requirements. Iowa may submit a summary worksheet that demonstrates how the rate was calculated using the CC PPS-1 methodology when, during the planning grant period, Iowa submits its PPS methodology to CMS for approval. The rate will include only those costs necessary to support the provision of CCBHC services.

B-10. Participating organizations

The CCBHC partner agencies and their roles are presented in the table below, and letters of commitment are included in Attachment 1.

<i>Organization</i>	<i>Specific Role and Commitment</i>
Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS)	MHDS administers Iowa’s Mental Health services and is the applicant and lead agency for the planning grant. MHDS will provide overall grant management and oversight. MHDS will work with partner agencies IME and IDPH to fulfill the goals of the grant, including oversight of project staff, participation in grant governance, stakeholder advisory and engagement activities, training and technical assistance, and engagement of MH providers in CCBHC grant activities.
Department of Public Health Division of Behavioral Health (IDPH)	IDPH administers Iowa’s substance use disorder services and is a partner agency for the planning grant. IDPH will partner with DHS to fulfill the goals of the grant, including oversight of project staff, participation in grant governance, stakeholder advisory and engagement activities, training and technical assistance, and engagement of SUD providers in CCBHC grant activities.
Department of Human Services (DHS) Iowa Medicaid Enterprise (IME)	IME administers Iowa’s Medicaid behavioral services and is a partner agency for the planning grant. IME will be the lead agency for development of the PPS. IME will be a partner in fulfilling grant activities, including oversight of project staff, participation in grant governance, stakeholder advisory and engagement activities, training and technical assistance and engagement of MCOs in CCBHC grant activities.
Iowa Association of Community Providers	Iowa Association of Community Providers (IACP) is comprised of over 135 community-based organizations. IACP will act as a liaison between the state and association members and will assist with coordination of provider / stakeholder meetings. IACP will assist with education and technical assistance as needed or appropriate for and between agencies.
Iowa Behavioral Health Association	IBHA is a non-profit organization with 30 member agencies that provide behavioral health prevention and treatment services throughout the state. IBHA provides education and technical assistance services. IBHA will provide support and collaborative planning with members and assist in outreach and education to members and other stakeholders.
Iowa Consortium for Substance Abuse Research and Evaluation	The Consortium is an alliance committed to strengthening substance abuse prevention and intervention activities through collaborative research. The Consortium coordinates research and knowledge transfer among researchers, assists professionals in the field, and informs public policy makers in the area of substance abuse. The Consortium will support the project with performance assessment and evaluation.

Iowa Mental Health and Disability Services Commission	IMHDSC is comprised of state and local government representatives, providers, consumers, and family members. IMHDSC provides oversight of the mental health and disability services system. IMHDSC will provide assistance in ensuring meaningful stakeholder input during the planning phase, and will be represented at stakeholder engagement activities.
Iowa Mental Health Planning Council	IMHPC provides monitoring and oversight of Iowa’s Mental Health Block Grant, and is comprised of a majority of persons in recovery and family members of children with an SED and adults with an SMI. IMHPC will provide assistance with ensuring meaningful consumer input in all phases of the planning grant and will be represented at stakeholder engagement activities.
Iowa Office of Consumer Affairs	The Office of Consumer Affairs (OCA) serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving and system navigation. The OCA provides a forum for obtaining stakeholder input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa. The OCA will provide assistance with ensuring meaningful consumer input in all phases of the planning grant and will be represented at stakeholder engagement activities.
State Board of Health / Program Licensure Committee (SBOH)	The SBOH is comprised of a range of healthcare representatives. The SBOH and its Program Licensure Committee provide oversight of the SUD services system. The SBOH/Committee will provide meaningful stakeholder input during the planning phase.
Iowa Department of Public Health Division of Tobacco Use Prevention and Control (TUPAC)	TUPAC is responsible for tobacco-related activities statewide. TUPAC is a division within IDPH and reports to the Tobacco Commission. TUPAC will provide policy level comment on planning grant activities and on development of the demonstration grant application related to tobacco use and smoking cessation and associated health considerations and will support stakeholder engagement activities related to tobacco use and smoking cessation.

B-11. Iowa support of CCBHCs in development of board governance

As part of the state’s licensure and accreditation processes for SUD and MH providers, Iowa has adopted standards to be met by service providers. The standards serve as the foundation of performance-based reviews of organizations for which the departments holds licensure or accreditation responsibility, as set forth in applicable sections of the Iowa Code. Standards enumerated in Iowa Administrative Code, Section 441, Chapter 24 (Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities) as well those contained in Section 641, Chapter 155 (Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs) specify requirements for an Advisory Board (under Chapter 24 programs) and a Governing Body (Chapter 155 programs). IHH are managed by the MCO and meet criteria established by IME in accordance with CMS requirements.

Iowa proposes to expand upon existing program requirements and incorporate its established standards for accredited CMHCs and licensed SUD providers with those necessary for complying with CCBHC certification requirements. As such, all CCBHCs will be required to have a governance structure that aligns with Program Requirement 6: Organizational Authority, Governance and Accreditation.

The state will establish policies for those entities designated as a CCBHC under the Demonstration and ensure that the governing body of each CCBHC incorporates meaningful participation by adult consumers with mental illness, persons in recovery from SUDs, and family members of CCBHC child and adult consumers, either through 51% of the board being

individuals with lived experience or their family members or through a substantial portion of the governing board members meeting this criteria and other specifically described methods.

Iowa will also establish policies requiring that members of the governing body represent the communities in which the CCBHC's service area is located. Iowa plans to mandate that no more than 50% of the governing board members may derive more than 10% of their annual income from the health care industry.

Through Planning Grant funds, Iowa will establish a series of learning communities in which potential CCBHCs will participate and receive technical assistance and training in the formulation of a governance structure, particularly to provide support for organizations that need assistance recruiting and establishing roles and processes that allow for meaningful consumer participation. The Iowa Mental Health Planning Council, the Iowa Office of Consumer Affairs, the Iowa Mental Health and Disability Services Commission, and the State Board of Health will partner with project staff in training and technical assistance regarding inclusion of consumers and family members in the governance process for CCBHC programs.

Section C: Staff, Management, and Relevant Experience

C-1. Capability and experience of Iowa Department of Human Services and participating organizations

As the applicant organization for this CCBHC initiative, the DHS MHDS, Iowa's designated State Mental Health Authority, currently administers the SAMHSA Community Mental Health Block Grant, the Projects for Assistance to Housing (PATH), is the accrediting entity for Iowa's CMHCs and other mental health and disability service providers, and provides oversight of the MHDS regions. DHS has also been a recipient of a SAMHSA System of Care expansion planning grant (2013-14) as well as a six-year System of Care program grant (2006-2012) providing MH services and supports to children with an SED and their families in a primarily rural area of Iowa.

The DHS IME has extensive experience in administering prospective payment systems for a variety of providers including managing the cost reporting process for a wide variety of MHDS providers. IME also received a Balancing Incentive grant, administers the State Innovation Models (SIM) grant, is involved in development of affordable care organizations, and implemented medical homes for individuals with chronic conditions, including Iowans with a SMI or an SED.

In 1995 DHS IME initiated the Iowa Plan for Behavioral Health to assure access to appropriate, high quality services, coordinate service delivery, and contain Medicaid costs. The Iowa Plan is jointly overseen by IME and IDPH.

IDPH, as Iowa's designated Single State Agency (SSA), is responsible for funding and regulating SUD services statewide. IDPH has extensive experience in managing large grants such as the annual Substance Abuse Prevention and Treatment (SAPT) Block Grant and associated State appropriations; Access to Recovery (2007-2017); Garrett Lee Smith Suicide Prevention (2013-2016); Iowa National Guard/Service Members/Veterans/ Families Policy Academy; Iowa Recovery Health Information Technology TCE (2012-2015); State Adolescent

Enhancement and Dissemination Grant (SAT-ED); Partnerships for Success and Strategic Prevention Framework State Incentive Grant (2009-2019); and Screening, Brief Intervention, and Referral to Treatment (2012-2017). IDPH is skilled in implementing projects with diverse stakeholders within prescribed timeframes.

DHS and IDPH have the ability to communicate broadly and on a daily basis via webinars, tele-health methods, conference calls, and in-person meetings. These varied resources assist in making implementation, joint planning, and sustainability a collaborative and streamlined process. DHS and IDPH have tested processes in place for data collection and analysis, access to content expertise, and an established track record of working effectively across systems and organizational structures.

The Iowa Association of Community Providers (IACP) represents mental health and disability services providers. IACP has extensive experience in training and technical assistance to its members and in stakeholder engagement activities.

The Iowa Behavioral Health Association (IBHA) represents mental health and substance use disorder services providers. IBHA has extensive experience in training and technical assistance to its members and in stakeholder engagement activities.

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium), located at the University of Iowa, is an alliance committed to strengthening substance abuse activities. For over 20 years, the Consortium has provided evaluation and reporting on the performance of IDPH-funded SUD services in Iowa, including the annual Outcomes Monitoring System report and bi-annual Iowa Youth Survey, and other projects such as Culturally Competent Treatment, Iowa National Guard/Service Members/Veterans/Families Policy Academy, Practice-Improvement Collaborative, SAT-ED, SBIRT, and SPF-SIG. The Consortium has extensive experience and expertise in researching special populations

The OCA, IMHPC, and Iowa MHDS Commission are all active participants in stakeholder advocacy and engagement activities in the Iowa behavioral health system. These entities all provide a venue for public input into the behavioral health system and include consumers and family members as active participants.

The SBOH is comprised of healthcare stakeholders and will provide meaningful stakeholder input on the SUD system.

The Iowa Department of Public Health Division of Tobacco Use Prevention and Control (TUPAC) is the lead agency for tobacco cessation in Iowa and will provide expert input into efforts to integrate tobacco cessation efforts into behavioral health settings including potential CCBHCs.

C-2. Staff positions, key personnel, roles level of effort, and qualifications

The table below includes the anticipated project team members, role description, designation of key staff, expected level of effort (LOE), and position qualifications.

<i>Position</i>	<i>Description</i>	<i>Key?</i>	<i>LOE</i>	<i>Qualifications</i>
Project Director, Laura Larkin, Executive Officer 2, Division of MHDS, DHS	SMHA employee providing project oversight; liaison to SAMHSA, SMA, and SSA for grant communication and activities	Y	.10 FTE in-kind	State-level policy and planning experience, experience with the mental health service delivery system, state contracting processes, and grant management experience.
Project System Lead, Theresa Armstrong, Bureau Chief, Division of MHDS, DHS	SMHA employee providing project and policy leadership; supervises Project Director and certain project staff	Y	.05 FTE in-kind	State-level policy, planning and supervisory position; experience with the mental health service delivery system and related state initiatives
Project System Lead: SUD Kathy Stone, Director, Division of Behavioral Health, IDPH	SSA employee providing project and policy leadership; supervises Project Director – SUD and certain project staff	Y	.05 FTE	State-level policy, planning and supervisory position; experience with the SUD service delivery system and related state initiatives
Project Director: SUD Michele Tilotta, Executive Officer 2, Division of Behavioral Health, IDPH	SSA employee providing project oversight; liaison to SMHA and SMA for grant communications and activities	Y	.10 FTE	State-level policy and planning experience, Substance Abuse Prevention and Treatment Block Grant manager; experience with SUD service delivery system, state contracting processes, and grant management experience
Project System Lead - SMA-Iowa Medicaid Enterprise, Deb Johnson	SMA employee providing project and policy leadership	Y	.05 FTE in-kind	State-level policy, planning and supervisory position; experience with the Iowa Medicaid system and related state initiatives.
Prospective Payment Systems Staff, TBD	SMA employee to oversee development of PPS structure and cost reporting process	N	.10 FTE in-kind	Bachelor's Degree or higher, fiscal management or Medicaid prospective payment system experience.
Evaluation Director	Dr. Stephen Arndt	Y	.10 FTE	Extensive experience with state level evaluation of programs and grants, ability to collect and analyze data in compliance with SAMHSA policy.
Project Manager, TBD	Contract SMHA staff responsible for carrying out the work related to achieving the project goals, including management of the training and technical assistance tasks, and working closely with multiple stakeholders in overseeing the evaluation and planning required of the grant.	Y	1.0 FTE at 11 months effort	1) baccalaureate degree in a relevant health field 2) experience working with the designated population and subpopulations 3) experience staffing interagency groups and/or experience working across state systems to make policy change 4) experience in developing successful grant applications 5) experience organizing training and technical assistance events
Program Planner, TBD	Contract SMHA and SSA staff responsible for working with the project director to achieve the project goals as detailed above; working closely with multiple stakeholders in overseeing	N	2.0 FTE at 11 months effort	1) baccalaureate degree in a relevant health field 2) experience working with the designated population and subpopulations 3) experience staffing interagency groups and/or experience working

	the evaluation and planning.			across state systems to make policy change
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C-3. Key staff qualifications

Key staff identified above have extensive experience in mental health and substance use disorder program administration and policy development. All three state-level partner organizations and the staff representing them have experience with successfully managing federal grants, working collaboratively with stakeholders and consumers to improve the system, and work collaboratively on multiple interagency projects. Biographical sketches of key personnel are located in Section E. Key personnel to be hired will meet the criteria identified in the attached job descriptions.

Section D: Data Collection and Performance Measurement

D-1. Collection and reporting on the required performance measures

Iowa has extensive experience with collecting, reporting, tracking, analyzing, and evaluating performance measures, including measures that support federal program evaluation efforts (i.e., ASPE’s evaluation of Iowa’s Medicaid Health Home benefit). Metrics in Section I.2.2 require planning grant awardees to minimally track eight required core measures (e.g., training programs implemented by organizations or communities; the number of professionals qualified to provide MH/SUD services consistent with CCBHC goals; financing policy changes; communities that established HIE/HIT systems linkages; collaborating resources developed as result of the grant, etc.) in addition to other optional measures identified by the state. Iowa is prepared to implement processes to collect the required data, track metrics, and perform quarterly reporting using the Common Data Platform (CDP).

Iowa has implemented and operates a number of large-scale initiatives that require the collection of many measures similar to those specified throughout the RFA, and particularly those mandated for receipt of CCBHC planning grant funds.

- **HEDIS:** The State monitors Medicaid quality activities with frequently used tools such as HEDIS and Consumer Assessment of Health Plan Study (CAHPS) as well as use of additional questions about access to care. University and research partners evaluate the programs and there are requirements for quality improvement programs and internal quality assurance systems in accordance with federal regulations.
- **Medicaid Health Homes:** Iowa offers health home services to Medicaid beneficiaries with either two or more chronic conditions, or one chronic condition and at risk of developing another. Iowa identified two key goals for the health homes program: (1) changes in consumer behavior to increase the use of preventative services, and increase awareness of appropriate chronic condition management and (2) transformation of provider practices by the adoption of the patient-centered medical home model to improve the population health of members. Qualifying chronic conditions include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, body mass index (BMI) over 25. Health home providers are required to implement an electronic health record (EHR), that includes referral tracking capabilities, and have in place a plan for complying with federal meaningful use requirements. Providers also must employ a population management tool, such as a patient registry, and are encouraged to use email, text messaging, patient web-portals, and other technology where possible to enhance patient access and self-management. Iowa has incorporated a P4P component into their health home program. Incentive payments are based

on achievement of selected quality and performance benchmarks that health homes will report annually to the state. These 16 measures are separated into five categories: preventive measures, diabetes/asthma measures, hypertension/systemic antimicrobial measures, mental health measures, and total cost of care.

- **The Outcomes and Performance Measures Committee:** The Outcomes and Performance Measures Committee (OPMC) was established by Senate File (SF) 2315 to present a framework and series of recommendations for the Department of Human Services to establish outcomes and performance measures for a continuous quality improvement system for the statewide mental health and disability service (MHDS) system. Outcomes and performance measures fall within six domains: Services, Life in the Community, Person-centeredness, Health and Wellness, Quality of Life and Safety, and Family and Natural Supports. The Department (IME) uses a survey process to collect and evaluate information directly from individuals and families receiving services and from the providers delivering these services.
- **Outcomes Monitoring System:** The Outcomes Monitoring System (OMS) was established to systematically gather data on substance abuse treatment outcomes in Iowa. Randomly selected clients from 22 IDPH-funded treatment programs are contacted for follow-up interviews approximately six months after discharge from treatment. Clients admitted in calendar year 2011 were selected to participate in the OMS project. The annual OMS report provides data and trending on specific outcome measures such as substance use, employment, income, family status, arrest and hospitalization.

Iowa ensures that internal state-level processes and structures are established to collect metrics that largely derive from state information systems (e.g., requiring the use of internal guidelines and protocols to adhere to collection of HEDIS). Similarly, the state ensures that the collection, tracking and reporting of provider-level measures are embedded in policies or other guidelines so that providers have an inherent process for conducting service and evaluation/performance activities. For example, provider standards implemented for the state's Medicaid Health Homes program mandated health homes' participation in training programs for providers to track and improve consumer outcomes, manage program data, and utilize tools to manage and share health information.

Iowa's process and structure for state/provider level data collection enabled the state to successfully inform ASPE's May 21, 2013 report entitled, "Medicaid Health Homes In Iowa: Review of Pre-Existing Initiatives and State Plan Amendment for the State's First Health Homes Under Section 2703 Of the Affordable Care Act."

Throughout the planning grant period, the state will assess the need to collect additional measures but will first ensure its ability to collect and report mandatory CCBHC metrics.

The state will implement similar training programs for CCBHCs. To support potential MH and SUD providers in transitioning to a CCBHC, the state will establish a series of learning communities, including an ongoing track dedicated solely to data collection and performance measurement.

D-2. Iowa state support to CCBHCs for continuous quality improvement

Iowa will assist CCBHCs in building performance measurement capacity, by building on NIATx principles and established infrastructure to support the health homes implement quality metrics. Iowa will evaluate providers' capacity to be a health clinic through use of a CCBHC readiness assessment instrument. Potential CCBHC sites with sufficiently high readiness will participate in practice transformation coaching to instruct and assist providers with quality improvement efforts and achieve CCBHC objectives. The results of the readiness assessments will inform development/refinement of ongoing training content. Providers will receive ongoing technical assistance, including during the two-year Demonstration phase. Learning communities will be the venue through which CCBHCs receive training and technical assistance. Entities likely to serve as DCOs will also participate in practice transformation coaching activities.

Iowa will mitigate any challenges providers may face as they build their performance measurement infrastructure through the infrastructure established for learning communities, practice transformation coaching and internal business processes established for state-level staff to interact with CCBHCs and directly address training/TA needs. Iowa will also seek to develop a single reporting format across CCBHCs to ensure early and consistent understanding of reporting expectations. Measure workgroups will be established to determine how measures will be defined and calculated across CCBHCs.

To further inform this process, Iowa will model CQI after IME's Medical Services Unit Guidance document that was used to engage potential Medicaid Health Homes. This Guidance document provided education, and described organizational roles consistent with health homes objectives, described the state's internal business process for becoming a health home, described steps involved for the Medicaid health home's "orientation," process for participation in the health home monthly webinar, described requirements for gathering and compiling information necessary to complete a monthly report to track enrollment of health home members, and communicated requirements for submission of quarterly reports.

DHS and IDPH will develop a similar guidance document for organizations potentially selected as CCBHCs.

D-3. Plan for performance assessment

Assessing progress during the grant period is critical to achieving the Planning Year objectives, and demonstrating readiness to implement the Demonstration. Iowa is committed to reporting progress achieved, barriers encountered and efforts to overcome these barriers on a quarterly basis. Iowa periodically reviews performance data submitted to SAMHSA as part of assessment and grant management. Iowa will utilize the process established for review and analysis of existing federal data requirements (e.g., TEDS and NOMS data) and adapt it for CCBHCs during the planning grant period. In order to assure that the planning process achieves its goals, a timeline detailing deliverables and due dates will be established at the beginning of the project. Project staff will refine the timeline, and deliverables added, altered, or removed as necessary and appropriate as part of project execution and monitor.

Iowa has demonstrated the capacity to conduct performance assessments. In 2004, IDPH convened professionals representing local and state public health to address the fragmentation of

the public health system in Iowa. This Work Group for Redesigning Public Health focused on system level Quality Improvement processes. Using data derived from state-level reporting, Iowa implemented two to three QI initiatives per year, with local counties participating in each round. In 2013, IDPH implemented a Public Health Tracking Portal to provide stakeholders access to certain IDPH databases and measures.

A key component of Iowa's behavioral health managed care plan over the past 20 years has been assessment of client satisfaction and perception of care. These efforts will continue under the new managed care plan going into effect January 1, 2016 and can be customized to consider CCBHC activities. Data from surveys, based largely on the Mental Health Statistics Improvement Program (MHSIP), historically show overall satisfaction indices around 91%, exceeding the benchmark of 85%. Analysis identified the following satisfaction "key drivers": "How satisfied were you with the help you got?," "I was able to see a psychiatrist when I wanted.," "My child is better at dealing with daily life.," and "I deal more effectively with daily problems."

In addition, IDPH generates a dashboard that displays the level of accomplishment of outcome measures and goals on a monthly basis. The data is used to inform project staff and stakeholders of progress towards goals, deadlines met, status of current and future activities. DHS is in the process of developing dashboards that describe key MH and disability service system outcomes. The project partners will consider a CCBHC dashboard as a method of reporting and monitoring outcomes.

Many existing state strategies that allowed transition to occur with little program interruption (regular stakeholder meetings, beginning with an assessment, providing targeted consultation, building on prior accomplishments, adjusting based on data) will be used to report and assess CCBHC performance. Data will be reviewed regularly by all state agency partners and stakeholders, and used at the state level as part of a QI process to identify infrastructure changes needed to support CCBHC implementation and to identify any changes required to keep the planning and implementation project on time and on target.

Iowa will provide written quarterly reports within 15 days of the close of the reporting period, and will share that information with CCBHCs, DCOs and stakeholders. The report will detail, for each deliverable due during the quarter, the status of the deliverable. It will indicate the progress that has been achieved, any barriers that were encountered and the efforts that were made to overcome the barriers. As an important part of continuous quality improvement, the State will share the entire reports with selected CCBHCs in a form that allows each CCBHC to benchmark its outcomes against those of other CCBHCs.

D-4. Potential challenges in data collection

Iowa is familiar with requirements necessary for the collection of data to inform national program effectiveness evaluations, is confident in its ability to collect data, and is committed to working with the national evaluation team on the design, data sources, and performance measures. Iowa's process and structure for state/provider level data collection enabled the state to successfully inform ASPE's May 21, 2013 report entitled, "Medicaid Health Homes In Iowa:

Review of Pre-Existing Initiatives and State Plan Amendment for the State's First Health Homes Under Section 2703 Of the Affordable Care Act.”

However, Iowa acknowledges the challenges that may be faced by the state and by providers in the application of standardized data collection processes for consumer-level data. Challenges will likely be encountered related to:

- Data (calculation of the measures) from providers that will be different and need to be normalized.
- Difficulties in obtaining data from DCOs to CCBHCs to the state.
- Difficulty obtaining data from comparison groups from providers and in communities where equivalent data is not collected in the same manner as collection for CCBHCs.
- The necessity for data sharing agreements.
- Data elements that are not currently collected by providers.
- EHRs lack functionality to collect or share data.
- Timeliness of receipt of claims data.
- Lack of clarity on how measure should be calculated for non-NQF measures.
- Data formats may be different and impact aggregation.

Iowa will mitigate these challenges through the infrastructure established for learning communities, practice transformation coaching and internal business processes established for state-level staff to interact with CCBHCs and directly address training/TA needs. Specifically, the state intends to establish regularly occurring meetings with Medicaid to generate reports; establishing workarounds when state IT systems are unable to be modified in a timely manner.

Iowa will also seek to develop a single reporting format across CCBHCs to ensure early and consistent understanding of reporting expectations. Measures workgroups will determine how measures will be defined and calculated across CCBHCs. The state will also provide support to CCBHCs to collect their own data and data from DCOs if relevant. And finally, state leadership will clarify and communicate expectations for cooperation across CCBHCs and other providers likely to be affected by data reporting to inform the national evaluation.

D-5. Preliminary plan for comparison group selection

Iowa plans to formalize the comparison group selection during the planning year, in consultation with project partners, including SAMHSA’s National Evaluators. In particular, Iowa will look to The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) to provide leadership in this decision. The Consortium will support the CCBHC project with performance assessment and evaluation and will collaborate on the national evaluation to formalize the method for selection of a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access services from other providers.

The Project Team will work with the Consortium to ensure that the comparison group selection is informed by the comparison group used for the evaluation of Integrated Health Homes. The comparison group selection for IHHs is as follows: One analysis compares the PMPM costs for IHH enrollees in the year prior to their enrollment in the program to those for the first 6, 12, and 18 months after joining. Costs are tracked and compared every six months. Researchers match each enrollee who has been in the IHH for one year with one who has been enrolled in Medicaid,

but not an IHH. They control for age, gender, and condition in the match, and adjust the regression using propensity scoring to reduce bias. The state will also compare hospital admissions and emergency department visits for these two groups, using HEDIS specifications. Nursing facility admissions will be assessed individually to determine the reason for admission and the associated costs. This strategy will be effective when comparing access, quality and available scope of services between CCBHCs and non-CCBHCs.

D-6. Data collection capacity to inform the national evaluation

Iowa has extensive experience with collecting, reporting, tracking, analyzing and submitting performance measures, including measures that support federal program evaluation efforts (i.e., ASPE's evaluation of Iowa's Medicaid Health Home benefit). The state relies heavily on the use of the Medicaid management information system (MMIS) and the data reporting and analytics capacity of IDPH and DHS to comply with CMS and SAMHSA information submission requirements. IDPH regularly uses ISMART (WITS) systems integrated with EHR systems and providing data to TEDS, NOMS, a Central Data Depository to integrate records, as well as specialized systems such as Access to Recovery (ATR) databased recording recovery oriented service delivery. DHS has a data warehouse for aggregation and analysis of client-level data from Medicaid and regional MHDS systems. MMIS and managed care data is readily accessible in a timely manner. MCOs have the ability to create customized reports upon request of the state. MCO's, accreditation, and licensure staff also have the responsibility to complete chart reviews to ensure that individual services are provided as required by standards of each entity. Iowa ensures that internal state-level process and structures are established to collect metrics that largely derive from state information systems (e.g., requiring the use of internal guidelines and protocols to adhere to collection of HEDIS). Similarly, the state ensures that the collection, tracking and reporting of provider-level measures and data are embedded in policies or other guidelines. For example, provider standards implemented for the state's Medicaid Health Homes program mandated health homes' participation in training programs for providers to track tracking and improve consumer outcomes, managed program data, and utilize tools to manage and share health information. Iowa's process and structure for state/provider level data collection enabled the state to successfully inform ASPE's May 21, 2013 report entitled, "Medicaid Health Homes In Iowa: Review of Pre-Existing Initiatives and State Plan Amendment for the State's First Health Homes Under Section 2703 Of the Affordable Care Act."

Data collected from CCBHC electronic health records (EHR) will further be utilized during the Demonstration program. Iowa is anticipating that the majority of CCBHCs will have EHRs capable of maintaining patient records and will have a common data analytics tool that can collect and analyze relevant data. Iowa understands that all of the necessary HIT enhancements are in the early stages, including building the capacity of a data analytics tool to report all of the required items, achieving interoperability between a data analytics tool and EHRs, and extracting information directly from EHRs. The State will work with selected CCBHCs either to assure that their various data analytic and EHR systems are capable of collecting and extracting needed data and information, to expand functionality to allow for these functions or to develop alternative data collection strategies.