Transition Plan for the movement of Psychiatric Medical Institutions for Children (PMICs) to the Iowa Plan

Submitted to the Legislative Interim Committee as required by Division III of SF 525 by the PMIC Transition Committee

January 16, 2012

Introduction

The Iowa General Assembly directed the Department of Human Services (DHS), through SF 525 to establish a Psychiatric Medical Institutions for Children (PMIC) transition committee ("Transition Committee).[1] Section 525 directs the Transition Committee to develop a plan for the transitioning of the administration of PMIC services from a fee for service program administered by the Iowa Medicaid Enterprise (IME) to the Iowa Plan, through which the IME provides managed behavioral health care to its Medicaid enrollees. The work of this Transition Committee is happening at the same time that DHS has convened a two-year effort to overhaul its mental health system for children. Section 525 required specific representation on the Transition Committee.[2] The Administration filed a preliminary report with the Interim Legislative Committee on October 31, 2011 as part of its larger report detailing the activities and progress of the Mental Health System Redesign.

Since filing that progress report, the PMIC Transition Committee has continued to meet and presents this Transition Plan. As described below, the Transition Committee recommends that the PMICs transition to the Iowa Plan without much substantive change to how they are managed today and with rate setting consistent with current processes. As required by Section 525, the Transition Committee will continue to meet through December 2013 to allow the PMICs and the Iowa Plan to have continuing discussion about the transition to ensure that it is as smooth as possible for the PMICs, and most importantly, the children they serve. In addition, the Transition Committee will continue to develop a process for payment of ancillary services through PMICs by July 2012. To assist PMICs in their ability to successfully provide medical and ancillary services to the children in its care, the Transition Committee recommends a statutory or regulatory requirement that providers participating in the Medicaid program be required to contract with PMICs and that they also be required to accept the Medicaid fee-for-service rates for providing care to children in PMICs.

Interaction with the Children's Mental Health Initiative

As described in our preliminary report, DHS is engaged in a statewide stakeholder effort to improve the children's mental health system in Iowa. The PMICs play an important role in the system today, and will continue to do so in the future. The Children's Mental Health Redesign Workgroup recognized that today PMICs cannot provide the optimal impact to children because of a disconnect with community-based services and a lack of appropriate step-down opportunities that impacts successful transition back to the community.

The Transition Committee reviewed and confirmed the vision for the overall Children's Mental Health Redesign as being the same vision for the PMIC. Specifically, under this vision, PMICs will continue to strive to provide services that are:

- **Coordinated**—at a child/youth and family level, at a community level and at a systems level, mental health and disability services are delivered with attention to integration, fluidity, efficiency, transparency, and child/youth and family outcomes.

[1] The full text of Section 525 is included as Attachment A.
[2] The membership of the Transition Committee is included as Attachment B.

- **Family and Youth-Driven**—focused on and adapted to the wishes, needs and strengths of a child/youth and his/her family and delivered through the optimal mix of natural, informal and formal services and supports.
- **Culturally Competent**—able to address the unique cultural and linguistic needs of children/youth and families, eliminating disparities in care, and create equity in outcomes.
- **Developmentally-driven and evidence-based**—to effectively engage and serve children and youth through the use of proven and promising prevention, early intervention and treatment practices, such as trauma informed care.
- **Flexible, nimble, nuanced, varied, specialized**—through collaboration, shared decision-making, use of a blend of formal, informal and natural resources and supports, and through persistence in assuring children/youth and families get what they need to optimally live, learn, work, and recreate in their communities and throughout life.
- **Delivered "where children/youth are"**—home, school and community-based supports designed to help children/youth succeed in their environment in ways that are most natural, normal, comfortable, usable and sustainable.
- **Accessible**—time-sensitive access across a full spectrum of services and supports promotes interventions that are upstream, available, welcomed, and least-restrictive.
- **Attentive to the journey and needs of parents, guardians, caretakers, and families**—through support and assistance in navigation, bringing voice and choice to decision-making, engaging with other parents and families.

The Transition Committee also endorsed the Children's Workgroup recommendations that PMIC services be:

- Flexible – a child can go back for brief stays when needed
- Accessible – no waiting list for admission
- Used more strategically for the highest need children
- Fully integrated within the children's System of Care
- Inclusive of family and community involvement in treatment
- Coordinated both on the front end (goal-directed, timely admission) and back end (carefully coordinated discharge to assure successful transition back to community and reduce need for readmission)

The ability to achieve these goals is inextricably linked to the efforts of the Children's Redesign workgroup.

Transition to the Iowa Plan

The Transition Committee has met three times between October 4, 2011 and December 7, 2011. As reported in our preliminary report, the Transition Committee explored the following issues:

- Identifying admission and continued stay criteria for PMIC providers (4b3);
- Evaluating changes in licensing standards for PMICs, as necessary (4b4); and,
- Evaluating and defining the standards for existing and new PMIC and other treatment levels (4b9).

Given the transition to the Iowa Plan within the context of the Children's Mental Health Redesign, the Transition Committee recommends that PMICs be transitioned to the Iowa Plan with no major changes to current administrative requirements or rate methodology. Having stability as the PMICs move into the Iowa Plan is important as the PMICs also face the potential for major changes to their programs based on the system redesign. In addition, the Transition Committee determined that it was difficult to evaluate and define standards for existing and new PMIC levels separate from the efforts of the Children's Mental Health Redesign. The Transition Committee plans to actively participate in this discussion as it occurs, allowing for PMICs to provide more flexible services, retaining its longer term residential capacity for children with high-end mental health needs while providing capacity for short-term stays to avoid longer stays or readmissions.

Administrative Requirements
The Transition Committee recommends limited changes to PMIC licensing and credentialing standards. Specifically, the Committee recommends that Administrative Rule Chapter 115 be amended to require that case workers be supervised based on their applicable licensing requirements, and not specifically require an hour of supervision per week regardless of licensing standards. The specific rule changes would be as follows (new language is in italics):

Administrative Code 441, Chapter 115 (Comprehensive Residential Facilities)

441-115.4(2) Staff duties.

> *a. If caseworker has a bachelor's degree in social work or human services, is a Licensed Master of Social Work, or is otherwise not licensed at the independent level (Licensed Independent Social Worker or Licensed Mental Health Counselor or Licensed Marriage and Family Therapist)*, a casework supervisor shall provide:
>
> (1) One hour per week per caseworker of in-person case specific supervision
>
> (2) On-site supervision at least monthly.
>
> (3) At least one additional hour per week per caseworker in other related duties including case intake discussions, staffings of cases, evaluations of caseworker, teaching, and administrative duties.
>
> *b. For facilities licensed under this chapter which are also licensed as a Psychiatric Medical Institution for Children under 481—Chapter 41, If caseworker is independently licensed as a Licensed Independent Social Worker or Licensed Mental Health Counselor or Licensed Marriage and Family Therapist , the caseworker shall operate under the standards applicable to the caseworker's licensing board.*

For admission and continued stay criteria (prior authorization), the Transition Committee recommends that the current process of allowing for up to 90 days for an initial authorization, and continued stays of up to 90 days at a time remain in place. However, in moving to the Iowa

Plan, the prior authorization process will move from a paper to a telephonic process, allowing for increased dialog and quicker resolution. Through this process, PMICs will have the opportunity to receive approval in advance of admitting a child into residential care through the Iowa Plan's intake queue that also reviews hospital admissions. Continued stay reviews will occur through scheduled calls with a dedicated reviewer. In granting initial and continued stay authorization, the Iowa Plan will utilize the state's current utilization management guidelines. Prior to the transition of the PMICs to the Iowa Plan, the Transition Committee will meet to review the initial and continuing stay guidelines and to review scenarios together to ensure joint understanding of the utilization management guidelines. As part of this meeting, the Transition Committee will discuss when and how joint treatment planning will be initiated on behalf of children currently residing in a PMIC. The Transition Committee recommends that the IME begin sharing current prior authorization approval/denial/modification rates for both initial admissions and continuing stays, and that the Iowa Plan continue to collect and regularly share that information with PMICs after the transition.

Baseline Measures

The Transition Committee recommends that the Iowa Plan begin to collect baseline data and to develop baseline measures of PMICs and community performance. To date, the Transition Committee has identified the following possible measures:

- Average length of stay
- Readmission (to any PMIC)
- Discharge plan in place at admission; followed in the community
- Family involvement throughout PMIC stay
- Discharge to desired living arrangement
- Consumer/parent satisfaction

Over the next six months, the Transition Committee will confirm these measures and define selected measures. Upon transition to the Iowa Plan, the Iowa Plan Contractor will begin to collect data and produce measures based on specifications. The measures will provide the state, the Iowa Plan, and the PMICs with a better understanding of the outcomes achieved by the children they serve. It is important to note that the measures will provide at least as much information on the availability and success of services in the community as it does on the performance of a particular PMIC.

Per Diem Rates

The Transition Committee determined to maintain the current rate setting methodology for base rates for PMIC services. In maintaining the current rate structure for PMICs in the first year under the Iowa Plan, rates will be based on actual and allowable costs to a maximum rate. The maximum rate will be 103% of the statewide average plus inflation. Under this methodology, the rate is expected to increase (retroactively) from $189 per day to $192.74 per day in July 2011 and $202.80 from August 2011 through June 2012.[3] As envisioned by the Transition Committee, for FY2013, the facilities will submit cost reports to the IME as they do today and will be paid an interim rate based on previous years retrospectively calculated rate. Based on the IME's calculations, the Iowa Plan will conduct a retroactive cost settlement with

[3] These rates will be finalized by the IME once the state receives a final cost report from one PMIC. The rates are not expected to change materially based on this submission.

each of the PMICs to adjust claims to the final rate. The Transition Committee will stay involved in and work towards consensus for any potential rate methodology change going forward as it is discussed in the context of the Children's Mental Health Redesign. There is consensus among Transition Committee members to move away from a rate methodology that depends on annual filing of cost reports and reconciliation over the long term.

While the Transition Committee recommends that the rate methodology remains stable at the transition of the PMICs to the Iowa Plan, the Committee also requests that state appropriations language for FY13 provide some flexibility to IME and the Iowa Plan in the payment of PMICs to allow for some modifications to allow PMICs to begin to better accommodate children who currently reside at out of state PMICs or are at risk of doing so.

Ancillary Services

Concurrent with the transition of PMICs to the Iowa Plan, the state will also begin to include coverage for all medical and ancillary services within a PMIC's rate for children within their care, as required by the Centers for Medicare and Medicaid Services (CMS). A subgroup[4] of the Transition Committee has formed and has met by teleconference twice to determine the least burdensome methodology by which to comply with CMS requirements. During its meetings, the subgroup discussions have included an overview of other states that have been required by CMS to make this change, including Oklahoma and Montana. Like those states, Iowa plans to develop an add-on to the per diem rate that bundles projected costs for all Medicaid covered medical and ancillary services that are projected to be utilized by children residing in PMICs. To develop this add-on, the IME will work with its actuary, Milliman, to review spending on medical and ancillary services for children in a PMIC. In addition to reviewing fee-for-service data from IME, it is also important to include services currently paid for by the Iowa Plan, including psychiatric services. All data developed for this process will be shared with the PMICs.

The PMICs will receive the add-on rate as part of each child's per diem. Overall spending by each PMIC on medical and ancillary services will be retrospectively reconciled on a quarterly basis. PMICs will have the ability to request a shorter time frame for reconciliation where a resident requires significantly more costly medical or ancillary services than anticipated in the per diem rate. IME may need to make system changes in order to ensure that claims can only be billed through the PMICs as of July 2012.

While the payment rate is likely to be relatively straight-forward following completion of data analysis, PMICs will require significant administrative support in order to be able to have the capacity to pay providers for these services. It requires additional staff and updated systems at each PMIC. The extent of the staffing and system updates depends on claims volume and on the ultimate payment process. As part of this discussion, the Ancillary Subgroup must also determine if and how prior authorization will occur for ancillary services paid for through the PMICs.[5] In addition, PMICs will require technical assistance in contracting with providers and best practices in payment processing. One potential option that the Ancillary Subgroup plans

[4] Members of the Ancillary Services subgroup are listed in Attachment C.

[5] Examples of ancillary services that require prior authorization today include, but are not limited to, radiology, durable medical equipment, dental services and pharmacy.

to look into is the use of a clearinghouse to provide many of these services across the PMICs, instead of each PMIC developing their own systems and staffing capacity to process claims. The viability of this option depends on the ultimate cost as well as whether CMS is amenable to this method.[6]

To ensure that PMICs are able to contract with Medicaid providers and are able to pay at the same rates as Medicaid fee-for-service, the Transition Committee recommends the addition of statutory language requiring that participating Medicaid providers contract with PMICs and that they accept Medicaid fee-for-service rates for services provided to Medicaid-eligible children residing in the PMICs. In addition, legislative language allowing for the IME to make these payments to PMICs may also be needed.[7]

Next Steps

The Transition Committee will continue to meet through the transition of PMICs to the Iowa Plan in July 2012, and beyond that through 2013 to ensure that the PMIC transition does not bring any unintended consequences and that the work of the Children's Mental Health Redesign continues to consider the role of the PMICs within the greater mental health delivery system for Iowa's children.

[6] A number of Medicaid providers utilize clearinghouses to process claims, include hospital and physician groups and school districts for their municipal Medicaid programs.

[7] Subsequent to the initial filing of this report, CMS has informed the Department of a change in the CMS policy, which may give the Department more flexibility in the way ancillary services are reimbursed. This will be a topic for committee discussion during the next quarter.

Attachments

A. SF 525
B. Transition Committee Membership
C. Ancillary Subgroup Membership

Attachment A: SF 525

DIVISION III

PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

Sec. 7. Section 135H.3, subsection 1, Code 2011, is amended to read as follows:

1. A psychiatric medical institution for children shall utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident. The membership of the team of professionals may include but is not limited to an advanced registered nurse practitioner or a physician assistant. Social and rehabilitative services shall be provided under the direction of a qualified mental health professional.

Sec. 8. Section 135H.6, subsection 8, Code 2011, is amended to read as follows:

8. The department of human services may give approval to conversion of beds approved under subsection 6, to beds which are specialized to provide substance abuse treatment. However, the total number of beds approved under subsection 6 and this subsection shall not exceed four hundred thirty. Conversion of beds under this subsection shall not require a revision of the certificate of need issued for the psychiatric institution making the conversion. Beds for children who do not reside in this state and whose service costs are not paid by public funds in this state are not subject to the limitations on the number of beds and certificate of need requirements otherwise applicable under this section.

Sec. 9. PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN AND RELATED SERVICES —— TRANSITION COMMITTEE.

1. For the purposes of this section, unless the context otherwise requires:

a. "Iowa plan" means the contract to administer the behavioral health managed care plan under the state's Medicaid program.

b. "PMIC" means a psychiatric medical institution for children.

2. It is the intent of the general assembly to do the following under this section:

a. Improve the reimbursement, expected outcomes, and integration of PMIC services to serve the best interests of children within the context of a redesign of the delivery of publicly funded children's mental health services in this state.

b. Support the development of specialized programs for children with high acuity requirements whose needs are not met by Iowa's current system and must be served in out-of-state placements.

c. Transition PMIC services while providing services in a manner that applies best practices and is cost-effective.

3. The department of human services, in collaboration with PMIC providers, shall develop a plan for transitioning the administration of PMIC services to the Iowa plan. The transition plan shall address specific strategies for appropriately addressing PMIC lengths of stay by increasing the availability of less intensive levels of care, establishing vendor performance standards, identifying levels of PMIC care, providing for performance and quality improvement technical assistance to providers, identifying methods and standards for credentialing providers of specialized programs, using innovative reimbursement incentives to improve access while building the capacity of less intensive levels of care, and providing implementation guidelines.

4.

a. The transition plan shall address the development of specialized programs to address the needs of children in need of more intensive treatment who are currently underserved. All of the following criteria shall be used for such programs:

(1) Geographic accessibility.

(2) Expertise needed to assure appropriate and effective treatment.

(3) Capability to define and provide the appropriate array of services and report on standardized outcome measures.

(4) Best interests of the child.

b. The transition plan shall also address all of the following:

(1) Providing navigation, access, and care coordination for children and families in need of services from the children's mental health system.

(2) Integrating the children's mental health waiver services under the Medicaid program with other services addressed by the transition plan as a means for supporting the transition plan and ensuring availability of choices for community placements.

(3) Identifying admission and continued stay criteria for PMIC providers.

(4) Evaluating changes in licensing standards for PMICs as necessary to ensure that the standards are aligned with overall system goals.

(5) Evaluating alternative reimbursement and service models that are innovative and could support overall system goals. The models may include but

are not limited to accountable care organizations, medical or other health homes, and performance-based payment methods.

(6) Evaluating the adequacy of reimbursement at all levels of the children's mental health system.

(7) Developing profiles of the conditions and behaviors that result in a child's involuntary discharge or out-of-state placement. The plan shall incorporate provisions for developing specialized programs that are designed to appropriately meet the needs identified in the profiles.

(8) Evaluating and defining the appropriate array of less intensive services for a child leaving a hospital or PMIC placement.

(9) Evaluating and defining the standards for existing and new PMIC and other treatment levels.

5.

a. The department shall establish a transition committee that includes departmental staff representatives for Medicaid, child welfare, field, and mental health services, the director of the Iowa plan, the department of inspections and appeals, a representative of each licensed PMIC, the executive director of the coalition of family and children's services in Iowa, a person with knowledge and expertise in care coordination and integration of PMIC and community-based services, two persons representing families affected by the children's mental health system, and a representative of juvenile court officers.

b. The transition committee shall develop the plan and manage the transition if the plan is implemented. A preliminary plan shall be provided to the legislative interim committee authorized pursuant to division I of this Act for consideration by the committee in October 2011. The completed plan shall be provided to the interim committee by December 9, 2011, and any revisions to address concerns identified by the interim committee shall be incorporated into a final plan developed by December 31, 2011, which shall be submitted to the general assembly by January 16, 2012. The submitted plan shall include an independent finding by the director of human services, in consultation with the office of the governor and the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, that the plan meets the intent of the general assembly under this section. Unless otherwise directed by enactment of the general assembly the department and the transition committee may proceed with implementation of the submitted plan on or before July 1, 2012.

c. The transition committee shall continue to meet through December 31, 2013, to oversee transition of PMIC services to the Iowa plan.

6. The director of the Medicaid enterprise of the department of human services shall annually report on or before December 15 to the chairpersons and ranking members of the joint appropriations subcommittee on health and

human services through December 15, 2016, regarding the implementation of this section. The content of the report shall include but is not limited to information on children served by PMIC providers, the types of locations to which children are discharged following a hospital or PMIC placement and the community-based services available to such children, and the incidence of readmission to a PMIC within 12 months of discharge. The report shall also recommend whether or not to continue administration of PMIC services under the Iowa plan based upon the quality of service delivery, the value of utilizing the Iowa plan administration rather than the previous approach through the Medicaid enterprise, and analysis of the cost and benefits of utilizing the Iowa plan approach.

Attachment B: PMIC Transition Committee Membership

Name	Organization	Title
Vern Armstrong	DHS	Field Operations Division Administrator
Mike Barker	Children's Square	CEO
Kermit Dahlen	Jackson Recovery Center/ Jackson Adolescent Center	CEO
Dan Freeman	Independence MHI	Director
Joan Discher	Magellan Behavioral Care of Iowa	General Manager
Deb Dixon	Department of Inspections and Appeals	Health Facilities Officer
Jim Ernst	Four Oaks	CEO
George Estle	Tanager Place	CEO
Gary Gansemer	Hillcrest	CEO
Don Gookin	IME	Bureau of Long Term Care Executive Officer 2
Gloria Gray	Children and Families of Iowa	Executive Director
Scott Halverson	Alegent Health Mercy Hospital	Southwest Iowa Program Manager
Dennis Janssen	IME	Clinical Director
Nick Juliano		Care coordination and integration of PMIC and community-based services expert
Marilyn Lantz	Iowa Juvenile Court	Iowa Juvenile Court Officer
Belinda Meis	Lutheran Services of Iowa	Director of Beloit Residential Services
LeAnn Moskowitz	IME	Management Analyst 3
Kristie Oliver	The Coalition of Family and Children Services in Iowa	Executive Director
Wendy Rickman	DHS	Adult, Children & Family Services Division Administrator
Rick Shults	DHS	Mental Health & Disability Services Division Administrator
Art Silva	Boys and Girls Home	CEO
Jennifer Vermeer	IME	Division Administrator
Brock Wolff	Orchard Place	CEO

Attachment C: Ancillary Subgroup Membership

Name	Organization	Title
Kermit Dahlen	Jackson Recovery Center/ Jackson Adolescent Center	CEO
Joan Discher	Magellan Behavioral Care of Iowa	General Manager
Tami Gilmore	Four Oaks	CFO
George Estle	Tanager Place	CEO
Don Gookin	IME	Bureau of Long Term Care Executive Officer 2
Gloria Gray/Amber Rand	Children and Families of Iowa	Executive Director
Deborah Gay	Lutheran Services of Iowa	CFO
Kristie Oliver	The Coalition of Family and Children Services in Iowa	Executive Director
Jennifer Vermeer	IME	Division Administrator
Valerie Saltsgaver	Orchard Place	CFO