To: Interested Parties
From: Cynthia Tracy, IME
Re: Public Input to the Iowa Plan
Date: October 27, 2008

In preparation for developing its Iowa Plan reprocurement the Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) and the Iowa Department of Public Health (IDPH) scheduled three opportunities for public input on the Iowa Plan. To guide the public input, the Departments developed a series of questions for which the Departments were interested in receiving input and feedback. The final questions were posted on the DHS's procurement website along with the meeting announcement.

Three public meetings occurred in mid-September. Twelve individuals and organizations provided oral input. In addition to oral input, five of the 12 provided written input. The IME also received written input from seven additional organizations.[1]

This report provides a summary of the topics and input provided at the public meetings and through written input. The Departments are considering each input comment to determine if and how to address each comment within the re-procurement of the Iowa Plan.

Public Feedback

This section of the report is organized by question. For convenience of the reader, each question for which an organization provided input is repeated below. The report includes a summary of all input received and does not differentiate between input that is or is not appropriately directed to IME, IDPH, or the Iowa Plan.

Question One

What specific steps should be taken to improve the coordination and continuity for Medicaid and/or IDPH-funded clients who receive their behavioral health services through the Iowa Plan, relative to the following services:

a. the continuum of behavioral health services
b. medical and behavioral health services
c. child welfare/juvenile justice and behavioral health services
d. home and community-based waiver services and health services.

Several organizations provided input regarding all or part of this question. One commenter provided general advice that the Iowa Plan would be better served by a single administrative entity instead of the joint management by the Departments or that the two Departments develop a work plan and timetable for better integration of services within the Iowa Plan.

[1] A list of organizations providing written testimony is included as Attachment B.

Relative to *the continuum of behavioral health services*, the Departments received input regarding the need for better coordination across all behavioral health and substance abuse services, as well as the need to integrate services across the behavioral health and medical systems. The commenter suggested that stakeholders should work together with the Departments and the Iowa Plan vendor to develop this aligned system.

A number of organizations provided testimony KStone: replace "testimony" with "input" that it should be a priority to reduce the average number of hospital days being provided to Iowa Plan clients and that the contractor should be required to develop adequate capacity to sub-acute care for those stepping-down from acute care. At least one commenter noted the need to increase pay for workers as part of developing an adequate supply of sub-acute care and to increase availability of case management services for children and adolescents. Another commenter expressed concerns at the possibility of including PMICs and remedial services in the Iowa Plan focused on access to care, management of" PMIC length of stays, and who would provide the remedial services. Additional questions related to how adding these services would impact rewriting Chapter 24A and 230A as well as how this RFP affects the Children's Mental Health and Emergency Services RFP.

In addition, input was provided regarding the burden of the utilization review process, particularly as it related to patients from one community being served initially in another community due to bed shortages and the approvals required to transfer the patient back to a hospital within their own community when a bed opens. A number of organizations suggested that in the next procurement the contractor should have the flexibility to forgo prior authorization reviews for providers with low denial rates to ease the administrative burden on providers and provide incentives for appropriate decision-making.

Commenters also noted the concern that not all services are equally available across the state. Commenters requested that there be a standard for minimum expectation of services for each county.

A number of organizations commented on the need for advisory groups made of direct care workers and staff "on the ground" and led by the contractor that can identify barriers to care and work towards solutions.

Relative to *medical and behavioral health services*, testimony described differences in utilization review between Medicare and the Iowa Plan. In Medicare, doctor-to-doctor review is often not required and services are audited at the back end.

Input also indicated that the system did not appropriately handle those with combination issues – whether dual diagnosis or those with a medical problem and mental illness. Input was also given suggesting that IME and its contractor become more familiar with CMS coding requirements for clients with a behavioral health diagnosis that receive medical services and to modify their claims system to be compliant with those guidelines. Input was also received around lack of funding to

assist parents of children with mental illness, despite fact that many interventions are appropriate at the family level.

For Iowa Plan clients with a medical issue and substance abuse issue who are uninsured, the current Iowa system does not promote easy access and/or engagement at the time of crisis. The commenter suggested that a model that promotes treatment at the time of crisis is best for a patient's needs.

Relative to the link between *child welfare/juvenile justice and behavioral health*, organizations provided input indicating concern over holes within the system given the reorganization of DHS and Juvenile Justice. That is, there is a belief that certain children are now falling through the cracks and are without services. Medicaid funding is not compatible with some evidence-based practices, such as functional family therapy. One commenter noted that work that has been done in Texas around the creation of an integrated Medicaid managed care plan for children in the state's foster care system.

Relative to *home and community-based waiver services (HCBS) and behavioral health services*, one commenter noted that there is a gap in services between high-end supports and community-based services for the MR/DD population. HCBS providers often are challenged to provide necessary services within the daily cap rate and therefore have a difficult time matching the level of supports offered in higher end settings. Additionally, because HCBS does not provide funding for congregated settings it is difficult to share resources across individuals. Finally, the commenter noted the lack of professional support for MR/DD providers and lack of clinical expertise to assist consumers with MR/DD that are in need of behavioral supports. One commenter noted the increased need for "wrap-around community-based support services" and the need for these services to be funded by the contractor.

Question Two

What specific steps should be taken to improved services for Medicaid and/or IDPH-funded clients with the following dual diagnoses:

a. mental illness and substance abuse
b. mental illness and developmental disability

As mentioned above, the Departments received input that the system does not adequately handle the needs of those with dual diagnoses. One example provided was lack of payment to hospital for certain assessments in the emergency room. One commenter suggested that the new contract must provide better coordination between the Iowa Plan and other static payment systems to ensure that the provider gets paid. Another commenter suggested that IME and the contractor establish new licensing requirements for providers that are certified for dual competencies in mental illness and substance abuse. With that certification, the commenter further recommended that the contractor should also develop a reimbursement rate that acknowledges the dual competencies. Another commenter noted that credentials should be required for providing services – not just that providers be certifiable. In addition, the Departments received input indicating that the co-occurrence of mental health and substance abuse is very prevalent. Given both the prevalence and the fact that many of the "treatments"

are not independent topics for one diagnosis vs. another, treatment for mental health and substance abuse should be comprehensive. One commenter suggested utilizing reinvestment funds to provide and enhance funding for integrated dual diagnosis treatment. Another suggested providing training to providers on how to manage dual-diagnosis patients.

The Departments received input requesting the contractor to consider paying for mental health and psychiatric evaluations for MR/DD clients who have been referred to rule out a mental illness. Further, the Departments received input indicating that because providers generally specialize in either mental illness or developmental disabilities, clients with a dual diagnosis often need to choose which diagnosis to be treated for as providers and funding streams vary. A suggestion, similar to that for mental illness and substance abuse, was for the contractor to establish new licensing requirements for providers that are certified for dual competencies in mental illness and developmental disabilities. The Departments also received input that it can be difficult placing adult clients with mental illness and mental retardation who are leaving the hospital. There is not adequate capacity for this and, at least one commenter, requested that this issue be reviewed. One commenter urged the Departments to allow mid-level practitioners working under clinical supervision to allow for continuity with providers and to ease capacity issues.

Further, commenters noted that some children in residential care with a developmental disability have significant behavioral issues that are not appropriately considered for RSP or remedial services. One commenter generally indicated that it is difficult to treat individuals with a dual diagnosis of mental illness and developmental disabilities along side individuals with only a mental illness diagnosis.

There was also a suggestion for behavioral supports and crisis intervention to be permanent services under the Waiver. To ensure services exist, it was suggested that the contractor also needs to pay adequate reimbursement rates.

<u>Question Three</u>
What specific steps should be taken to improve provision of IDPH substance abuse services in the next Iowa Plan contract?

Input included a suggestion that inpatient detoxification services should be included as a funded substance abuse service in the new procurement. Additionally, the commenter suggested that funding should be increased for substance abuse residential beds as a step-down from inpatient detoxification. Another commenter suggested that the contractor utilize two levels of detoxification services – a medical service (outpatient) with nursing care available and a "social detox."

The Departments also received a suggestion that there should be a determination of what substance abuse services are available along a continuum and within the Iowa Plan. It is important that counties be consistent on what is included and what funds are utilized for services. As an example, addiction treatment is not always covered. IDPH should work with counties to coordinate funding. In addition, IDPH should establish

contracts with 135B licensed hospitals to pay for substance abuse services and 1-3 day detoxification hospital stays.

At least one commenter believes that it is imperative that current regions be maintained, believing that this regional funding structure allows support for necessary infrastructure.

One commenter provided a suggestion that community reinvestment grants should be made public to allow for access to best practice models across the state. The commenter also requested that the practice of providing only one outpatient contract per catchment area be discontinued.

Question Four

How should the contractor work with CPC's, counties and/or local public health entities?

The Departments received input indicating that the contractor should be required to work closely with each of these entities as well as with practitioners that provide direct services to clients and with hospitals with inpatient psychiatric units. Some commenters favored open forums for communications, updates and feedback. In addition, a commenter suggested utilizing a centralized website or broadcast any changes to all entities. As mentioned previously, a number of organizations testified that it is important to set a minimum standard for services for persons with mental illness or substance abuse disorders across Iowa. However, other commenters noted that counties are capped by amount of revenue they can raise. Because there is a set pot of money, spending more to create a minimum set of services will likely result in other service shortages in counties that need to increase services to meet the minimum. One commenter suggested that it would be helpful if the RFP could build in some better coordination of the contractor and CPCs when children are transitioning from the child to adult level, the process differs from county to county.

One commenter noted that counties should be accountable to pay for services rendered at an acute facility when patient is sent there by the county for an emergency need, including when an individual is waiting for a bed at a state facility.

Lastly, a commenter suggested that there needs to be a long-term plan developed to identify funding sources for COD clients. The plan should include all stakeholders and require the contractor to participate in such plan development.

Question Five

What support services would be most helpful to the community to provide educators and others with adequate support to meet needs of children with serious behavioral health issues who often have difficulty in school settings?

The Departments received input noting that best practice models of mental health services delivery for children and their families, such as the Systems of Care Model, emphasize the need for a tiered system of health promotion and prevention with

targeted intensive intervention. The interventions should include family and community. Support for educators and others must begin with training and support to early child education and care and continue into school years to provide tools to identify deficits before they become barriers to learning. IME's role in the ABCDII project and expansion of First Five projects should continue and be expanded.

One commenter provided input that the contractor should work with and fund school districts that would like to provide school-based therapy services. Another commenter noted that in considering use of school-based therapists, it is important to take into account the roles of Community Mental Health Centers and utilizing their staff along with independent therapists.

Another commenter noted that remedial services have been successful to support children having trouble in the school setting and should be continued. Also regarding remedial services, a commenter noted that it is difficult to manage remedial services based on a cost cap and need to reconcile payments.

<u>Question Six</u>
What role should the Iowa Plan contractor play in the rollout of the new emergency service provider program?

The Departments received input on the new emergency service provider program noting that it could ease unnecessary emergency room usage. Further, input indicated that the contractor should provide funding for emergency and crisis services provided to Iowa Plan clients as part of the new ESP program. In addition, commenters urged that the contractor ease notification and authorization requirements for emergency and crisis services. Other commenters suggested that it would be very helpful to have an electronic statewide system that identifies available inpatient beds. Another commenter suggested that the funding of this initiative and expanding the availability of emergency mental health crisis intervention teams could be a responsibility of the Iowa Plan and could take some burdens away from hospital emergency rooms.

One commenter suggested that the contractor be included as part of the emergency service RFP selection committee.

<u>Question Seven</u>
How could the state improve the clinical assessment process for Iowa Plan Clients?

Commenters indicated that it was not feasible to have a standard assessment form due to diverse requirements for assessments depending on provider and level of care; however, organizations suggested that the contractor could provide education and workshops to assist providers in understanding the assessment principles. Input included a suggestion that if the contractor is going to deny care for an individual, the contractor should complete its own on-site assessment for treatment need. Beyond the assessment services, one commenter noted that it is important to look at the assessment process and see how quickly services are obtained after the assessment. In order to

ensure that individuals can get services within 24 hours, the contractor may need to expand provider capacity.

A number of commenters focused on assessments for children and adolescents, noting that they are not adequately funded and that they don't fund assessments needed by the juvenile court. In addition to concern about assessment funding, one commenter raised an issue regarding the underfunding of psychiatric medical checks. This is seen as a particularly important issue due to the shortage of psychiatrists interested in participating in Medicaid. Another commenter suggested more comprehensive assessments for children that looked at both the child's mental health and a family assessment.

Question Eight

Please provide suggestions on how the consumer and family perspectives can best be heard during the procurement process.

A number of commenters suggested that the Departments could work with organizations such as NAMI Iowa, Advocates for Recovery, Recovery Centers to identify and include consumers and/or their families in the evaluation of proposals. One commenter suggested using ICN to receive statewide input and additionally advocated for a longer period of written input.

Question Nine

Please provide suggestions on how the mental health provider perspectives can best be heard during the procurement process.

One commenter suggested that a variety of provider associations could be invited to identify members for potential inclusion in the evaluation of proposals. Another commenter suggested that remote and rural areas should have ability to provide input through electronic methods, teleconferences and formal requests. As mentioned above, one commenter suggested utilizing ICN and noted that it is important that mental health and substance abuse providers be involved in all stages of re-procurement.

Question Ten

How useful are the performance incentives and disincentives included in the current vendor contract and how should they be enhanced in the re-procurement, if at all?

One commenter opined that when quality standards are met it's based on the work of Iowa providers, not the contractor. The commenter suggested that performance incentives should not be part of the contract going forward. Another commenter noted that the system of incentives needs to be transparent. Equitable awards should be provided to the providers.

Question Eleven

Aside from incentive and disincentive considerations, how should the state's current vendor contract be modified for the future to ensure the vendor selected for the next contract provides effective and efficient services to Iowa Plan clients?

A variety of suggestions were provided in response to this question.

- One commenter noted that direct services are provided by Iowa providers, not by the Iowa Plan vendor and that it is important to adequately reimburse providers for their services.
- The contractor should not receive interest off of unspent funds; moreover, there should not be unspent funds where there are waiting lists for services.
- The Departments should work with the Iowa Department of Economic Development to structure the contract to ensure adequate provider reimbursement to attract and retain needed behavioral health providers in Iowa.
- Client outcomes must be considered as well as cost savings.
- A longer-term vision of systematic measures would benefit everyone.
- The need for precertification and verification of level of service is time consuming and of no value to the patient; the commenter suggested use of random audits instead of all upfront work.
- Expand telemedicine opportunities for behavioral health services.
- To assist with workforce capacity issues, the new contract should be flexible in working with provider community to recognize a number of service models and significant use of mid-level practitioners.
- Develop a manageable "days awaiting placement" payment system and establish observation payment for "23 hour" stays.
- Allow providers to bundle claims appeals into a single hearing; include an independent claims appeal process within new contract.
- Consider not requiring accreditation by the National Committee for Quality Assurance (NCQA) for bidders to qualify. Either allow for bidders to be in the process of obtaining accreditation or hold another accreditation (such as URAC).
- Do not require bidders to have a fully contracted provider network at the time of proposal submission; this provides the current vendor with an unfair advantage.
- The vendor needs to understand Iowa and unique challenges facing delivery of services in a rural state as well as workforce challenges.
- Vendor must understand substance abuse dynamics and history.
- Effective and efficient behavioral health services must be recovery based. The procurement should support existing recovery-based programming and consider adding additional programming into the Iowa Plan such as WRAP (Wellness Recovery Action Planning) and Illness Management Recovery.
- The contractor should provide more in terms of health prevention.
- The contractor should provide more education and training to allow providers to leverage best practices across state.
- The contractor should be required to make a fair and reasonable effort to contract with providers in other states to assure access for those in border communities.

Attachment A – Public Meeting Attendance List

A star next to an individuals name denotes that the individual provided oral input during the public meetings.

Name	**Organization**
Kathy Penkert*	Penkert Consulting
Neil Fagan*	Iowa Health - Des Moines
Sally Roy*	Mercy Medical Center
Deanna Triplett	Iowa Behavioral Health Association
Chris Sims	Magellan
Dennis Peterson	Magellan
Gloria Scholl	Magellan
Lauren Hansen	Lutheran Services Iowa
Paula Dwornicki*	Lutheran Services Iowa
Carolyn Cleveland*	Foundation 2
Jamie Anderson*	Boys & Girls Home
Christie Gradert	Family Resources, Inc.
Sandra Quilty	Orchard Place
Brock Wolff*	Orchard Place
Carolyn Hejtmanek	Orchard Place
John Stineman	Lincoln Strategies Group
Greg Boattenhamer	Iowa Hospital Association
Shannon Strickler*	Iowa Hospital Association
Sabra Rosener	Iowa Health System
Georganne Cassidy-Wescott*	Iowa Health System
Julie Smith	Iowa Health System
Christine Gregory*	Family Resources
Jean Duncan	Iowa Health Physicians
Ben Khan	Employee and Family Resources
Katsler Le	Broadlawns
Kevin Carroll	Broadlawns
Cindy Peterson*	Cenpatico Behavioral Health
Karen Clayton*	Mercy DSM – Behavioral Health
Marilyn Austin	Iowa County CPC
Judith Fox*	Family Resource Center and the Bridge of Hope

Attachment B – Written input

Name	Organization
Neil Fagan	Iowa Health - Des Moines
Patrick Costigan	REM Iowa, Inc.
D. Lowell Yoder	University of Iowa Hospitals and Clinics
Brock Wolff	Orchard Place
Karen Clayton	Mercy DSM - Behavioral Health
Greg Boattenhamer	Iowa Hospital Association
Sam Donaldson	Cenpatico Behavioral Health, LLC
Debra Keele	St. Lukes Regional Medical Center
Julie Shepard	Iowa Behavioral Health Association
Thomas Eachus	Black Hawk-Grundy Mental Health Center, Inc.
Ann Harrmann	Coalition for Family and Children's Services
Marv Fangman	Clearview
Shannon Evers	Golden Circle Behavioral Health/Eyerly-Ball CMHS
Jan Heikes	Allamakee and Winneshiek Counties