

# **MENTAL HEALTH SERVICES MANAGEMENT PLAN Policies and Procedures**

**consortium of:  
Audubon, Greene and Guthrie Counties, Iowa**

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Geographic Area: This policies and procedures manual covers the area encompassed by the three counties, Audubon, Greene and Guthrie and the residents thereof.

Section I. SYSTEM MANAGEMENT

A. Plan Development.....	3
1. Planning entity.....	3
2. Stakeholder involvement.....	3
3. Summary of stakeholder input.....	3
B. Plan Administration.....	3
1. Organization.....	3
2. Administrative budget.....	3
C. Financial Accountability Process.....	3
1. Rate setting and reimbursement.....	3
D. Risk-Bearing Managed Care Contracts.....	3
E. Funding Policy.....	3
F. Conflict of Interest.....	4
G. Provider Network Selection.....	4
1. Contracting.....	4
H. Delegated Functions.....	4
I. Access Points.....	4
J. Staffing Plan.....	5
K. Application Form.....	5
L. Consumer Access.....	5
M. Consumer Eligibility.....	5
1. Financial Eligibility Criteria.....	5
2. Clinical Eligibility Criteria.....	5
3. Co-Payment.....	6
N. Confidentiality.....	6
O. Emergency Services.....	7
1. Committal Protocol.....	7
P. Waiting Lists.....	7
Q. Quality Assurance.....	7
1. System Evaluation.....	7
2. Quality of Provider Services.....	8
R. Collaboration.....	8
1. Collateral agencies.....	8
2. Medicaid Mental Health Access Plan (MHAP).....	8
3. Chemical Dependency Services.....	8
4. Committal Protocol.....	8
S. Ongoing Education Process.....	9

Section II. PLAN ADMINISTRATION

A. Application/Intake Procedure.....	10
B. Eligibility Determination.....	10
C. Notice of Decision.....	10
D. Referral.....	10
E. Consumer Plan Development.....	10
F. Request for Funding.....	11
G. Service Funding Authorization.....	11
H. Service and Cost Tracking.....	11
I. Service Monitoring.....	11
J. Appeals.....	12

Section III. ANNUAL REVIEW / THREE-YEAR STRATEGIC PLAN..... 12

## GLOSSARY OF TERMS

- Access point: Agencies, offices or people with the knowledge, training and approval to complete applications, determine eligibility and legal settlement. *(page 13)*
- CMI: Chronic Mental Illness AKA Serious and Persistent Mental Illness. *(see definition page 17)*
- Consortium: Collaborative group of three counties (Audubon, Greene & Guthrie) acting jointly on the basis of a 28-E agreement for the purposes of meeting the mandates to maintain a central point of coordination process as set forth in SF 69.
- Coordinator (CPC): Mental Health Coordinator employed by the consortium and acting as the central point of coordination for the consortium. *(page 11)*
- County Management Plan: Mandated document written by counties under the direction of the Department of Human Services which specifies the methods whereby counties will manage mental health fund costs, access, enrollment, delivery and re-authorization of services to people with disabilities.
- CPC: Central point of coordination; administrative entity, designated by counties to act as the single point of entry to the service system. *(page 11)*
- CSALA: Community supported apartment-living assistance program designed to assist people to move to and/or maintain themselves in their own home.
- Developmental Disability (DD): Severe and chronic limitations as a result of mental or physical impairments occurring between the ages of 5 and 22. *(page 17)*
- DHS: Department of Human Services. Division of the State which delivers to the counties local services, regional case management, purchase of service system and state-county assistance.
- HCBS/MR Waiver: Home and community-based services under the administration of the Medicaid program specifying support services funded to maintain mentally retarded people in their own homes or small group homes.
- ICF/MR: Intermediate Care Facility for the Mentally Retarded. Licensure level of residential services which is more intensive than RCF/MR to serve people with more severe limitations and/or medical needs.
- ICP/IPP: Individual care/program plan that addresses the whole-person needs of those who are enrolled for service funding.
- Intake point: Agencies, offices or persons utilizing the system established by the consortium to gather basic information and formally refer a person seeking services/supports to an access point. *(page 13)*
- ISAC: Iowa State Association of Counties. Represent the counties as support and lobbying entity.
- Mental Health Center: Accredited agency providing a full range of mental health services to a specified area.
- Mental Health Fund: The county fund created in 331.424A.2, Iowa Code which exclusively covers all expenditures allowed for services to people who are diagnosed with mental illness and/or mental retardation.
- Mental Retardation MR: *(see definition page 17)*
- MHAP (Mental Health Access Plan): Managed care plan for Medicaid eligible people qualifying for mental health services as specified in the plan administered by MBCI, Merit Behavioral care of Iowa.
- MHI: Mental Health Institution. Licensed as ICF/MR and operated by the State of Iowa.
- MIS: Managed information system: Typically a computer data base program that organizes information (data) such that service usage and expenditures can be monitored closely and useful planning conclusions can be drawn over time. CoMIS is the current data base program used.
- POS: Purchase of Services. System for contracting and monitoring with private providers of Title XX services, maintained and operated by the State.
- RCF, RCF/MR, PMI: Residential care facility including designated, specialized care for people with mental retardation or people with mental illness.
- Supported Employment: Employment, either individual or group (i.e. work crew), which is typically acquired

with the assistance of professional staff and training and on-going supports by means of regular job coaching, in the community with wages paid by the employer.

Work services: Includes all work-related services traditionally referred to as work activity and sheltered work.

## SECTION I. SYSTEM MANAGEMENT

### A. Plan Development

The planning entity for the development of this plan is the consortium of Audubon, Greene & Guthrie Counties, including the Mental Health Coordinator, all Supervisors, provider agencies, DHS Case Managers, consumers, parents of consumers, representatives of consumer advocacy entities, and any interested parties. These people and entities are involved in the process in various, meaningful ways, which usually changes for each planning period. No single planning entity exists which is solely responsible for the development of the strategic plan. The processes may include formal three-county planning entity, consumer surveys or interviews, or parent of consumer surveys, planning meetings with one or more of the listed parties. Public hearings are held annually in each consortium county prior to final approval of the strategic plan by the Boards of Supervisors.

### B. Plan Administration

The central point of coordination and administration of the county mental health funds and management plan will be directly administered by the Coordinator for the consortium. No services or functions will be contracted for.

1. Organization: The Coordinator will act as the designee for the Board of Supervisors regarding matters of administration of the mental health fund and this plan. The Coordinator will be supervised as an employee of the consortium by an Executive Board consisting of three supervisors (one from each county board), appointed by the Boards. The Coordinator will work collaboratively with the auditor in managing the mental health fund.

### County Board of Supervisors

#### Executive Board

Auditor

Coordinator

### C. Financial Accountability

A management information system will be utilized to track consumers, budgets, expenditures and encumbrances in each county. Actually two systems track expenditures, that used by the Auditor's office to produce warrants, and that used by the Coordinator, currently the CoMIS program supplied by the State of Iowa. The county accounts are audited by the State of Iowa on an annual basis.

1. Rate-setting and reimbursement: Rates for service reimbursement for providers will be that which is negotiated for between the counties and each provider. Typically, services will be reimbursed after the delivery of the service, for the previous month. The Auditor's office in each county makes reimbursements based on an itemized invoice, specifying the services delivered, dates, number of units of service, credits, and net charge to the county.

### D. Risk-Bearing Managed Care Contracts

The consortium of counties does not contract with a management organization at any level in providing the central point of coordination functions.

### E. Funding Policy

Each county in the consortium will only be responsible for funding those services within the parameters that are specified in this plan. Funding for any service is contingent upon completion of the process to determine eligibility "enrollment" and the initial service authorization by the CPC. A second contingency will be the availability of funds

in the service area that is approved. At any time funds are determined to be fully encumbered for a service type, new people may either be put on a waiting list or receive authorization for limited service funding. If required, waiting lists may be used for any eligibility group or service other than for those services provided on the basis of entitlement programs. Notification with expected time frames for waiting will be made by use of the Notice of Service Authorization form.

#### **F. Conflict of Interest**

Utilization/service authorization will be the ultimate responsibility of the Coordinator and/or Supervisors. The “Notice of Service Authorization” and “Request for Services” forms will be completed by the Coordinator and provided to each enrollee and service provider prior to billing for county mental health funds. No party, except the Coordinator or county Board of Supervisors, will be authorized to approve funding for services that are not court ordered or for mental health psychotherapy. Other conflicts which may come to the attention of the Coordinator will be addressed at the source, or the team for the consumer. Such conflicts of interest may include, but are not limited to: 1) provider staff include a relative of the consumer; 2) a Supervisor is related to a consumer, in which an appeal is filed; 3) a Supervisor or family of a supervisor are a provider of services; or 4) the Coordinator is related to the consumer or the provider of services. In the case of a conflict of interest, the Coordinator will communicate to the consumer and the effected parties in writing, for purposes of notification of the conflict and in regard to the resolution of the conflict. In general the person for whom the conflict exists will be excluded from playing their customary role in the system, and the process will proceed so as to not delay necessary benefits or services to the consumer, either without the conflicted member, or with a replacement.

#### **G. Provider Network Selection**

The consortium will continue to purchase from and contract with those providers that are receiving MH funds as of 7/1/96. New providers must fall into one of the following categories before a new contract or service payment agreement will be implemented, or demonstrate that they comply with comparable standards which will adequately address the individual needs of the identified consumer(s), in a safe manner.

- Accredited by a national accrediting agency for the service(s) they are funded for
- Licensed by the representative official agency for the care/services being provided
- Certified by the representative official agency for the care/services being provided
- Approved by the representative official agency for the care/services being provided

1. Contracting: Contracts will be completed with each provider from which the consortium counties purchase services. These contracts may at times be duplicate contracts, previously negotiated by other counties or ISAC. The contract must contain, as a minimum, qualification standards, services, reimbursement rates and quality measurement criteria. Likewise contracting may be completed with non-traditional providers. The coordinator will assist such providers in developing quality practices, procedures and facility standards criteria.

#### **H. Delegated Functions**

Central point of coordination functions will not be delegated, except in the case of mental health committals and outpatient services delivered by mental health centers and “other providers”. In these cases the providers will gather core consumer data and make it available to the Coordinator. Thus, the Coordinator will ensure that these entities will comply with Iowa Code section 331.440 and 441- Chapter 25 in the completion of these delegated duties.

#### **I. Access Points**

Access points for MH/DD funded services will be the local DHS offices in each county, DHS Case Management and Mental Health Centers and other mental health providers which the consortium counties contract with throughout the region. These offices will be assisted by and work jointly with the

Coordinator. The Coordinator is an access point for the consortium. These entities (excluding mental health centers) will be responsible for completion of the application form, SSBG and other program eligibility determination. Final confirmation of mental health fund service eligibility will be the sole responsibility of the Coordinator, except in state cases. Applications will be forwarded from access points to the office of the Coordinator by the end of the working day in which they are received. The Coordinator will provide one-on-one training and assistance to the access point staff in application process functions as needed or requested.

## **J. Staffing Plan**

The consortium of counties employs one central point of coordination administrator staff person by means of a 28-E agreement and a common contract. That person is qualified with a bachelor of science degree or higher, with experience as required by Code. Elected county or state officials will not be employed in the capacity of the central point of coordination “Coordinator”.

## **K. Application Form**

Application forms are made available by the coordinator for access point personnel and anyone requesting same. Applications of any format will be accepted as long as the minimum necessary information is made available to the coordinator. This minimum core data information includes: name, Social Security number, current address, income, resources, addresses from age 18, date of birth, Title XIX number, diagnosis (DSM-IV), residential arrangement, gender, education, veteran status, marital status, guardianship information, employment status.

## **L. Consumer Access**

1. Routine Access: The consortium of counties offers a wide continuum of services starting with the least restrictive, as identified by a team planning process. Typically the least restrictive support is the most individualized and cost-effective.
2. Access Without Legal Settlement: Consumers may be enrolled and services may be funded by the consortium, in spite of the lack of legal settlement in a county in the consortium. The coordinator or case manager will contact the county in which the consumer appears to have legal settlement, or the state when it appears that they have state case status. Completion of an application and any other functions required to enroll the consumer in the home county, or with the state payment program will be completed in the county in which the consumer accessed the system. Eligibility determination will be completed by means of a comparison of consortium criteria with home county or state criteria. Likewise, service authorization will be completed by means of a comparison of standards between the two counties. Eligibility notification will be made to the consumer and service funding approval will be communicated to the provider within the same time frames as for any consumer. Enrollment and service authorization may be altered at the direction of the home county or state, once either entity claims responsibility for the funding of the consumer’s services.

## **M. Consumer Eligibility**

1. Financial eligibility criteria:
  - a) Meet countable net income\* guidelines of 125% of poverty level
  - b) Apply for all available public assistance programs available, appeal denials, and fulfill all program requirements so as to remain eligible
  - c) Resource limits for cash within SSI guidelines of \$2000.00
  - d) Resource limits for home of \$40,000 tax assessed value and autos of \$15,000 blue book value
  - e) Capital assets of less than \$5,000 total value (i.e. precious stones, precious metals, financial instruments and any and all properties but not cash)

f) Have exhausted all other sources of payment (i.e. health insurance, state/federal funds)

g) Person served and funded by the counties in the consortium prior to 7/1/96

2. Clinical eligibility criteria \*:

a) Mental health problems/mental illness; Person who has a DSM IV Diagnosis and can benefit from out-patient psychotherapy or who is committed by the court for services.

b) Chronic mental illness; Person who has a DSMIV diagnosis and displays a persistent, serious dysfunction or has received services/supports as a result of a diagnosed emotional disorder as specified below:

Treatment History Criteria: To be qualified as chronically mentally ill the person will meet at least one of the following criteria.

i. Have undergone psychiatric treatment that was more intensive than out-patient care more than once in a lifetime; or

ii. Have experienced at least one episode of continuous structured, supportive residential care other than hospitalization.

Functioning History Criteria: To be qualified as chronically mentally ill the person will meet at least two (2) of the following criteria for at least two (2) years.

i. Unemployed, employed in a sheltered setting, or have markedly limited skills and a poor work history.

ii. Require financial assistance or out-of-hospital maintenance and may be unable to procure such assistance without help.

iii. Show severe inability to establish or maintain a personal support system.

iv. Require help in basic living skills.

v. Exhibit inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system.

c) Mental retardation; Person with developmental, ongoing, significant deficits in adaptive behavior manifested before the age of 18 with an IQ of 75 (regardless of testing variances) or less.

\* Note: Persons diagnosed with developmental disability may only be enrolled for funding from county mental health funds as an exception, approved by the Board of Supervisors. Persons with a diagnosis of DD may have access to the full array of services as described in this plan, as part of the exception process and will be served in the entitlement programs of case management and ICF/MR. Persons who were being served as of 7/1/96 may continue to be served.

\* Note: Brain injured persons with onset occurring at age 22 or over will not be covered by this plan.

\* Note: Persons diagnosed with dementia illnesses or as substance abusers will not meet the diagnostic eligibility criteria of chronic mental illness.

3. Co-payment:

A co-payment system has been developed such that consumers who have income and/or resource in excess of the guidelines may participate in funded services. The purpose of such a provision is to assure that persons receiving services are not hampered in attaining self-sufficiency by the disincentive of ineligibility. The Personal Liability Policy is available upon request from the coordinator and the coordinator will apply the criteria specified to each case as is necessary.

## N. Confidentiality

The CPC and all agencies, offices and providers will be responsible for managing information about a consumer in compliance with all federal, state and local laws. This information will be shared with each of the county Auditors Offices. Specifically:

- No person shall disclose personal information about a person receiving services funded with county mental health moneys with any other entity without that person's (or representative for) written permission.
- No person shall disclose mental health or medical information about a person receiving services funded with county mental health moneys without the person's (or representative for) knowledge of the specific information to be released.
- No person shall disclose information about a person receiving services via county mental health funds which was produced by a third party without the knowledge and consent of the third party.
- No person shall discuss personal information about a person receiving services via county mental health funds in a public setting, or when an unauthorized audience may hear such confidential information.
- Authorization shall be obtained on a consent or authorization form, of which a copy shall be retained in a file containing consumer information, to demonstrate that release of information was authorized and completed.

## **O. Emergency Services**

Individuals seeking services in an emergency may access them through local law enforcement or local medical centers/hospitals 24 hours-a-day, 7 days-a-week. Under emergency situations funding enrollment is approved for up to two business days prior to the completion of an application form. Emergency means circumstances which cause a person to be at immediate risk of harm because of lack of shelter, food, medication or other care when other supports are not available.

### **1. Committal Protocol**

The committal protocol for each of the counties in the consortium is as follows. The mental health referee or magistrate or district court judge, as is allowed by Code, responsible for the county in which the person is found, will hear all applications made for involuntary committal for persons alleged to be seriously mentally impaired or chronic substance abusers. The referee or other judiciary can use any licensed hospital or chemical dependency treatment provider which will accept the individual with private personal resources such as health insurance, Medicaid, or Medicare, however the counties will reimburse only state mental health institutes, unless the county(ies) have a contract with a hospital for inpatient treatment. Inpatient charges for people committed by the court to a private or public facility as seriously mentally impaired will not be funded by the county if they have Medicaid or private health insurance that covers mental health. Charges for treatment at an MHI will be paid, however full reimbursement to the county by the patient will be sought.

## **P. Waiting Lists**

At any time that budgeted funds become fully encumbered, new applicants may be placed on a waiting list for funding. The consumer will be enrolled as usual, however services may not be authorized until such time that funds are made available or at the time of the new budget year. The consumer will receive a notice of decision notification which explains that they are enrolled, that they are on a waiting list for services, and how long to expect to wait for services funding to begin. In lieu of implementing this waiting list policy, the consortium county may opt to authorize and fund services at a less than full-time basis, for example, fund work services for less than five days per week. The criteria used to make this determination will be the individualized team planning process, addressing the specific circumstances and needs of the consumer.

This waiting list policy does not apply to some consumers who are accessing entitlement programs. As part of the annual planning process, the coordinator will factor in the implementation of the use of the waiting list policy for the following year's strategic plan, as well as in the budgeting of funds.

## **Q. Quality Assurance**

1. System evaluation: The process for evaluation of the system includes an annual comparison of the incidence of service utilization movement by means of CoMIS tracking and hand calculation. The

planning team will determine which services are tracked.

- a) Consumer's quality of life, empowerment, responsiveness, and satisfaction measurements will be completed by means of surveys, personal interviews and direct testimonials as part of participation in planning team activities.
  - b) Provider satisfaction will be determined by gathering information as part of planning team activities such as interviews, attendance at meeting, and surveys.
  - c) Patterns of service utilization will be targeted as prioritized in the strategic plan and tracked by means of CoMIS or hand calculated.
  - d) Appeals and corrective actions will be reviewed and plans will be implemented as directed by the planning team process.
  - e) Cost-effectiveness will be monitored as part of the strategic planning and review process.
2. Quality of provider services: To evaluate consumer satisfaction, evaluation processes will include a portion which is provider specific. Appeals of provider actions and subsequent corrective actions will be evaluated by an annual contract development process. This process will include an evaluation which assures that services were delivered in accordance with the contract, is consumer outcome oriented, and is cost-effective. This evaluation process is the sum of contract development and system development activities, and may include additional practices when new services are being developed, or for problem resolution.

## **R. Collaboration**

1. Collateral agencies: The Coordinator will maintain information regarding other agencies and programs which may benefit consumers including the following:

- Services provided; types, scope and hours of operation and availability
- General eligibility and cost criteria
- Accessing/Application process; contact person and method

Such services/agencies may include:

- Income assistance such as; SSI, AFDC, Food Services, Social Security, General Relief, Emergency Assistance, etc.
- Housing Assistance, Regional Housing Authority, rental subsidies
- Employment Assistance; Job Service (Work Force Center), Job Training Partnership Act, DVRS, Job Corp Center, etc.
- Health/Medical care, Public Health, HHA
- Transportation
- Education; Adult Basic Education, Community College, University
- Court Services
- Substance Abuse Services

2. Medicaid Mental Health Access Plan (MHAP): The Coordinator will communicate with MBCI to coordinate the new utilization criteria being developed as part of this plan. Other specific functions of this coordination:

- Assure that MBCI is paying for behavioral health care costs of consortium residents as required.
- Coordinate the development of new lesser-restrictive services and utilization protocols to match.
- Communicate with the Department to track baseline expenditures related to thresholds for 100% MBCI coverage.

3. Chemical Dependency Services: The Area XII Alcoholism & Drug Treatment Unit agency serves each county in the consortium and each county contributes funds for the provision of prevention and treatment of residents. However, these funds are not under direction of the Coordinator or this plan, but are paid from a fund other than mental health. The Coordinator will work to assist Area XII in

addressing needs assessment, information and referral, accessing services, and coordination with other mental health

service providers. Obviously, many persons with primary diagnoses other than chemical dependency also will need support and services for substance abuse problems as part of their comprehensive care plan.

Another area of concern shared between the counties and Area XII is that of committals. As part of managing and refining a protocol for mental health committals the issues of affecting meaningful and consistent results with substance abuse committals will be pursued.

4. **Committal Process:** The committal process for each of the counties in the consortium is as follows. The Mental Health Referee, Magistrate, or District Judge should at all times direct that the on-call mental health professional be contacted prior to determination that the person requires in-patient, hospital evaluation. The 24-hour mental health professional may be reached at:

*Audubon County: 800/562-6060; Greene County: 800/830-7009; Guthrie County: 800/562-6060*

- If it is necessary for the consumer to be hospitalized, the referee or other judiciary can use any licensed hospital or chemical dependency treatment provider which will accept the individual with private personal resources such as health insurance, Medicaid, Medicare, or assurance of private pay.
- If it is necessary for the consumer to be hospitalized and he/she has no known coverage for inpatient hospital treatment of mental health, he/she should be ordered to and evaluated at Cherokee MHI.
- If it is necessary for the consumer to be hospitalized, he/she has no known coverage for inpatient hospital treatment of mental health, and he/she will not be admitted to Cherokee MHI, the consumer should be ordered to and evaluated at hospitals as follows:

*Audubon County: St. Anthony Regional Hospital, Carroll, 712/792-3581, or  
Broadlawns Medical Center, Des Moines, 515/282-5752*

*Greene County: Mary Greeley Medical Center, Ames, 515/239-2011  
Trinity Regional Hospital, Fort Dodge, 515/573-3101*

*Guthrie County: St. Anthony Regional Hospital, Carroll, 712/792-3581, or  
Broadlawns Medical Center, Des Moines, 515/282-5752*

## **S. Ongoing Education Process**

The new planning process currently being developed will guide the education process, so as to educate and inform the public and potential consumers, which will empower them. Also, as part of the school-to-adult transition activities, either the Coordinator or a Case Manager attend IEP staffings for older students, or meet separately with students and families to inform them about the adult system. Management Plan Guides offer written information in a very user-friendly format and are available and distributed by the Coordinator, which describe the system and resources specific to each of the three consortium counties. The Guides describe what services are available and how to access them. Public hearings allow for the direct exchange between the public and the Boards of Supervisors regarding questions or concerns about the Plan.

## SECTION II. PLAN ADMINISTRATION

### **A. Application/Intake Procedure**

Consumers and/or any party on their behalf may apply at any one of the access points listed, whether in person, or by supplying the necessary written information. Staff at the access points will assist the consumer in completing an application and in gathering necessary documentation. Staff at access points will forward the completed applications to the Coordinator in the same business day completed. Additional information will be gathered in a timely manner by whomever possesses the application, with the assistance of the Coordinator as is needed. The Coordinator is the only party that can determine county mental health fund eligibility and will act on completed applications within 10 working days.

#### Court System:

Consumers may access services through the court mental health referee or district court committal process. All mental health centers/providers are authorized to screen voluntary admissions to Cherokee MHI also. Detailed information may be found on page 34 under committal protocol.

### **B. Eligibility Determination**

Eligibility for specific services will be driven by the team planning process. As long as the requested service is shown to be funded for the consumer's diagnostic group in the Services Funding Table, the level of services meets the least restrictive criteria, and funds are available, the consumer will be eligible for the team's recommended services. The eligibility determination for services funding, service authorization, will often be completed at the time a notice for general eligibility is completed, which is within ten (10) working days of receiving a completed application. In the case that the initial service authorization is not completed with the notice, it will be determined within ten (10) more working days, and a service authorization notification sent. Services and supports which are required immediately will be authorized immediately, for consumers which are otherwise generally eligible for mental health funding. Subsequently, the full eligibility and service authorization processes will be carried out.

### **C. Notice of Decision**

The consumer will be notified of his/her eligibility status by use of a notice of decision form within ten business days after the fully complete application is receive. The notice of decision form will include an explanation of the approval/denial. In most cases the notice will specify for what services funding is approved, although this may not be provided until a service authorization is completed within the following ten days. The notice will include waiting list information, including estimated length of wait, and how to get information about the length of wait. The notice of decision form will also include the right to appeal

and the specific protocol for filing an appeal for specific services will be driven by the team planning process.

#### **D. Referral**

The consumer, upon completion of the application process will be referred for services to any number of approved providers of direct, collateral and case management services. The application form itself will be provided to the Coordinator by the access staff in the same day that it is completed. In most cases the Coordinator will provide copies of the Notice of Decision and Service Authorization forms to the entities to whom the referrals are being made. A signed Authorization to Release Information form will be completed with the assistance of the consumer and/or guardian prior to releasing confidential information.

#### **E. Consumer Plan Development**

The counties in the consortium make use of Department of Human Services Targeted Case Management services, and thus referral is generally made between the Coordinator and the DHS Case Management supervisor, and/or one of four case managers located within the four counties. In most cases the Coordinator purchases 100% county case management from DHS when there is not a case manager, case worker, or other case coordinator. In some instances, the consumer is served by an “in-house” social worker and for services that are short term, or county funded for a short term. In these cases, an ongoing case manager may not be hired.

#### **F. Request for Funding**

The case worker, manager, or social worker for the consumer shall contact the Coordinator regarding the plan developed by the team. Preferably she/he will present a Request for Funding form which specifies the services, frequency, number of units and costs to the county. In practice, the services may be authorized by phone to expedite the provision of services, to be followed up with the Request for Funding form.

#### **G. Service Funding Authorization**

The Coordinator reviews and authorizes all requests for funds. Case reviews and renewal of services/funding requests are completed by the Coordinator, by means of either reviewing reports completed by a case worker, manager or social worker in the form of update report, phone conference, personal meeting, formal provider staffing, or the OAP. The plan for the consumer is developed by the team and “tweaked” by the Coordinator to address the individual circumstances by means of negotiating with the case manager/worker. The initial authorization usually is completed immediately, and the written form will be delivered to the person submitting the request within 10 working days. The renewal of the authorization will be completed on an annual basis in most cases. The authorization renewal will also be completed within 10 working days.

In cases in which the person has legal settlement in another county, the Coordinator and/or case manager will communicate with the “home” county and pursue the enrollment and service authorization protocol of that county. The Coordinator will communicate with the CPC of the home county before service funding is authorized. Services will be approved by the Coordinator if the process of coordinating with the home county will extend the approval process beyond the 10 working day limit. Services will be approved which best reflect the balance of the services authorization and provision parameters of the two counties.

In cases in which the person is believed to be a state case, the Coordinator and/or case manager will initiate and follow through with the state case protocol, as specified by DHS. Services will be implemented, within the parameters identified in the protocol, so as to not delay the provision of services. Emergency services may be funded by the county to assure the safety and well-being of the applicant.

#### **H. Service and Cost Tracking**

Two management information systems (MIS) are employed to track services utilization and expenditures, both based on the county chart of account codes. The first consists of the system that each of the three county auditors use for tracking all department's expenditures. This system is programmed and maintained by the CMS company, in Ames, Iowa. The second system is the CoMIS system, which is a program that is provided and updated by the State of Iowa. The Coordinator enters all expenditures per consumer, based on the county chart of account codes, and allows more detailed reporting that is required by the state. The CoMIS program allows the Coordinator to track the utilization per diagnostic group, per service area, and per specific service. This allows for system monitoring and planning for change, as well as responsibly managing the mental health funds.

### **I. Service Monitoring**

Services are currently monitored through the case monitoring activities of the targeted case managers. The southwest region of CPC's, as well as the state CPC collaborative, through the assistance of ISAC are pursuing a formal, and preferably uniform system of contracting between counties and providers, which will specify the standards and methods for completing service monitoring.

### **J. Appeals**

A person (or representative for) seeking services/funding through the consortium may appeal eligibility and service authorization decisions made by the Coordinator. The "Notice" forms clearly state the process by which people may appeal the decisions. Each person will have the opportunity to meet with the Coordinator regarding a negative disposition of their funding eligibility.

Appeals Protocol:

- Contact the Coordinator in person or by phone at 800/254-3054
- Write to the Coordinator at 114 N. Chestnut, Jefferson, IA 50129
- Call or write to a county supervisor

The Coordinator will meet with the person making the appeal, or schedule him/her with one or more of the county supervisors for that county, within 5 business days. The Coordinator will provide written notice to the person within 10 days of the meeting. If the person is not satisfied with the results of the meeting with either the Coordinator or supervisor, he/she will be scheduled on the agenda of the Board of Supervisors to make a second determination regarding eligibility or funding. Written notice regarding the results of the meeting with the Board, if not disclosed immediately, will be provided within 10 business days. In the case that the person bringing the appeal is not satisfied with the outcome of the meeting with the Board, he/she may then schedule a meeting with an appeal board made up of regional Central Point of Coordination administrators. This meeting will be scheduled within 10 business days and is the last action of appeal that may be taken. Written notice of the results of that meeting will be provided either immediately or in writing, within 10 business days.

In the circumstance that the person making the appeal has case state status, the Coordinator will assist he/she in completing the appeal procedures found in 441—Chapter 7.

## **Section III. ANNUAL REVIEW / THREE-YEAR STRATEGIC PLAN**

### **A. Annual Review**

A review of the management plan will be completed each year, to be submitted by December 1<sup>st</sup>. The Coordinator will draft a report which both details and summarizes data and information as specified in rules. This report will be provided to stakeholders, DHS and the state county management committee.

**B. Three-Year Strategic Plan**

The Coordinator will develop a strategic plan for submission with this policies and procedure management plan on April 1<sup>st</sup>, 2000, and three years thereafter. This plan will be submitted to the Department of Human Services and will include all necessary information as specified in rules. The Coordinator will be responsible for making corrections and providing supplemental information necessary to provide and approved plan.