Meeting Notes

Division: Department of Health and Human Services, Iowa Medicaid
Meeting Topic: REACH Implementation Team: Services and Providers Subcommittee
Facilitator: Carol Mau, HHS
Date: 06/10/2025
Time: 4:00 PM
Location: Virtual

Meeting Objectives

Implementation Team meetings create the opportunity for key stakeholders to facilitate and support the adherence to the Iowa REACH Initiative Implementation Plan objectives and activities and to provide coordinated oversight and recommendations to ensure the success of the Iowa REACH Initiative.

Meeting Participants

- Amy Berg-Theisen
- Carol Mau
- Gretchen Hammer
- Jen Royer
- Kim Hagen
- Laura Leise
- Marisa Cullnan
- Steve Sherman
- William Linder

Agenda Topic and Items

- Identification – How will youth and families learn about REACH?
    - Participants discussed that most individuals learn about behavioral health intervention services (BHIS) through internal referrals, such as during transitions from Psychiatric Medical Institutions for Children

(PMIC). Other referral sources include schools, judges, hospitals, community providers, and self-referrals.
    - Participants discussed gaps in communication and barriers to access. A major barrier is staying updated on current providers, especially in rural areas. Case managers may not always be aware of available services.
        - There is a lack of a centralized service directory or navigation path, making it difficult for families to understand available options.
        - The requirement for therapy concurrent with BHIS services complicates access, especially when therapists are not part of the same agency.
    - Inconsistent quality of service and referral follow-up have diminished public trust in service availability.
- Access – How will youth and families access REACH?
    - Participants discussed the lack of a consistent statewide process for accessing BHIS screenings and assessments.
        - Access can vary based on agency practices, funding, and how therapists write assessments.
        - Participants identified an opportunity to standardize training and language for writing assessments.
    - Participants supported the idea of establishing a formal referral process through child-serving professionals to access the REACH services.
        - Suggested parties who should be educated about the assessment process include families, schools, juvenile court staff, and healthcare providers such as pediatricians.
- Eligibility – Who is eligible for REACH IHCSTS?
    - Participants discussed whether children with serious emotional disturbance (SED) attributable to disabilities should also be eligible under REACH, even if not required by the agreement.
        - Participants raised concerns about the definition of “attributable to disability” and whether children may be unfairly excluded due to a low IQ score or developmental disabilities.

        - Participants requested clarification about whether eligibility is based on diagnosis, functional impairment, or both.
        - Participants emphasized the importance of using a licensed practitioner's judgment while also ensuring that diagnostic criteria are clearly defined and inclusive.
- Eligibility – Who determines eligibility?
    - Participants discussed that requirements for a licensed practitioner to determine REACH eligibility can act as a barrier and limit access due to workforce shortages.
    - Participants agreed that once assessments are completed, service delivery should be driven by a treatment team.
- Eligibility – How are eligibility determinations communicated?
    - Participants described the current process for communicating eligibility determinations as follows: assessments are completed, authorizations are submitted to managed care, then MCOs notify both the requester and the member.
    - Participants noted the use of an availability portal by providers helps reduce wait times and track authorization decisions.
- Assessment - What is the assessment process?
    - Participants agreed that the six-month reassessment requirement is useful. Challenges and inefficiencies arise when multiple assessors are involved without coordination.
        - Reassessments are used to evaluate progress over the previous six months and determine whether treatment plans are evolving with evidence-based practices.
        - If progress is slow, reassessments help identify whether new goals or more frequent interventions are recommended.
    - Participants discussed the gap in support for families during the time between referral and care delivery.
        - Families may receive 4-6 weeks of services without formal authorization, especially in urgent situations like preventing PMIC placement. This support is often uncompensated and insufficient

to stabilize families. Currently, crisis services are the only formal option, which is not ideal.
        - Participants suggested a pre-authorization model to allow limited services before full approval.
- Transitions – What are the steps to transition from REACH? What would the youth transition to?
    - Participants noted that transitions are typically managed through member-centered meetings (MCMs) or warm handoffs between providers. Participants recommended clearly defining roles to improve coordination and accountability during transitions.
        - MCMs are facilitated by MCO case managers, but participants noted that effectiveness varies. MCMs should not be the sole method for ensuring safe and stable transitions.
    - Participants discussed using BHIS to help stabilize youth transitioning out of intensive services. Other supports include crisis services and Integrated Health Homes (IHH).
        - Participants also expect that certified community behavioral health clinics (CCBHCs) will play a role.
- Discussion
    - None.
- Public Comment
    - None.

New Items: None.