OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier: LLARKINPI

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier: IA

8. APPLICANT INFORMATION:

* a. Legal Name: Iowa Department of Human Services

* b. Employer/Taxpayer Identification Number (EIN/TIN): 42-6004568

* c. UEI: Q7P9B28J8BY4

d. Address:

* Street1: 1305 E. Walnut St.

Street2:

* City: Des Moines

County/Parish:

* State: IA: Iowa

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 50319-0114

e. Organizational Unit:

Department Name: Iowa Dept. of Human Services

Division Name: Behavioral Health/Disability

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name: Laura

Middle Name:

* Last Name: Larkin

Suffix:

Title: Project Director

Organizational Affiliation: Iowa Dept. of Human Services

* Telephone Number: 515-303-0982

Fax Number:

* Email: llarkin@dhs.state.ia.us

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Substance Abuse and Mental Health Services Adminis

11. Catalog of Federal Domestic Assistance Number:

93.829

CFDA Title:

Section 223 Demonstration Programs to Improve Community Mental Health Services

*** 12. Funding Opportunity Number:**

SM-23-015

* Title:

Cooperative Agreements for Certified Community Behavioral Health Clinic Planning Grants

13. Competition Identification Number:

SM-23-015

Title:

CCBHC Planning Grants

14. Areas Affected by Project (Cities, Counties, States, etc.):

Map of IA Cong Districts.pdf | Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Iowa CCBHC Planning Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: IA-003 * b. Program/Project: IA-ALL

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/30/2023 * b. End Date: 03/29/2024

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☒ a. This application was made available to the State under the Executive Order 12372 Process for review on 12/19/2022.

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Marissa

Middle Name:

* Last Name: Eyanson

Suffix:

* Title: Director, Behavioral Health and Disability

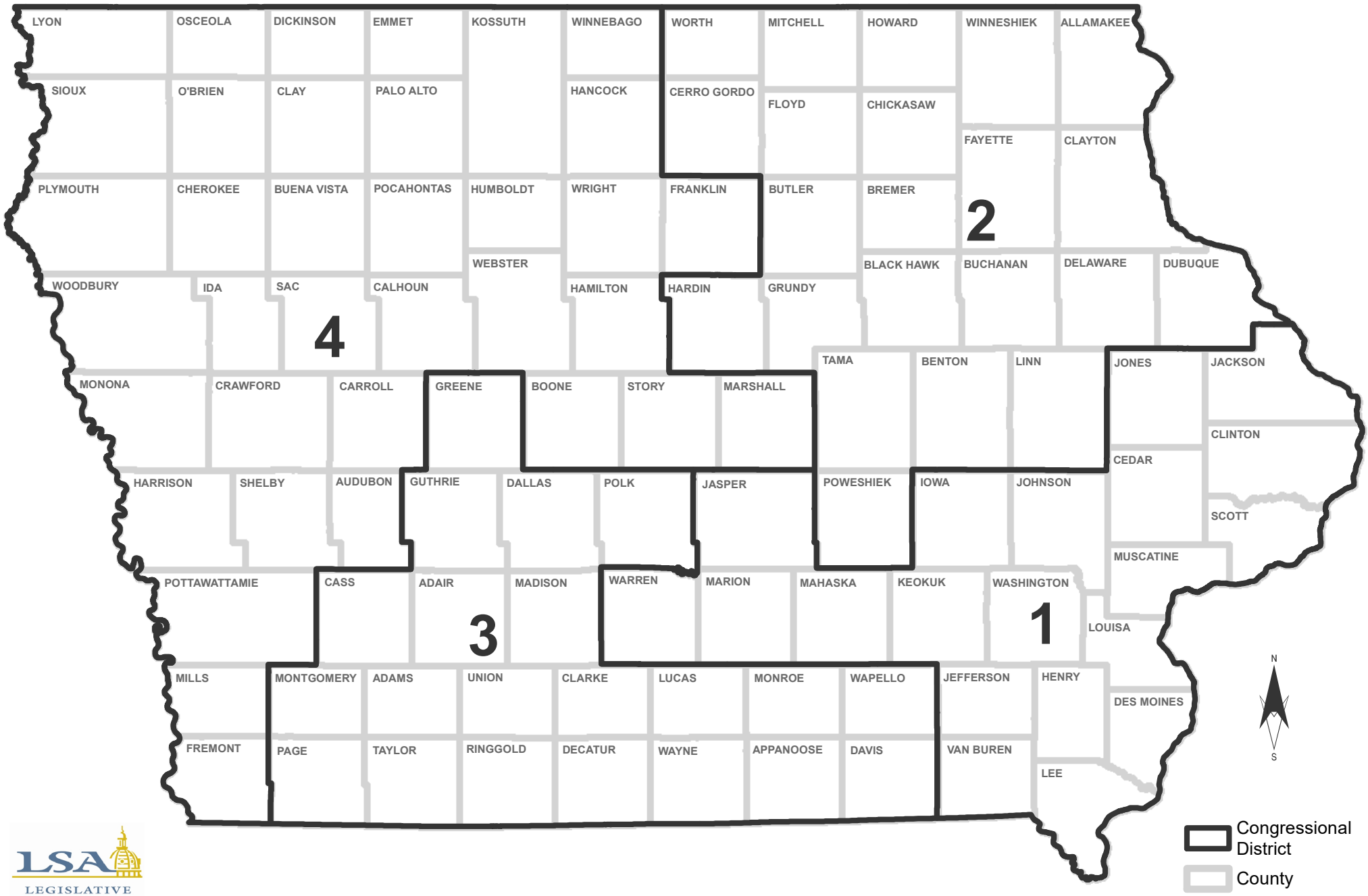
* Telephone Number: 515-281-8580 Fax Number:

* Email: meyanso@dhs.state.ia.us

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

IOWA CONGRESSIONAL DISTRICTS

Effective Beginning with the Elections in 2022 for the 118th U.S. Congress



LSA LEGISLATIVE SERVICES AGENCY

Prepared by the Iowa Legislative Services Agency

PREVIEW Date: Dec 19, 2022

Workspace ID: WS00994306 Funding Opportunity Number: SM-23-015

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2025

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SM-23-015 CCBHC Planning Grants	93.829	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	SM-23-015 CCBHC Planning Grants				
a. Personnel	$ 75,000.00	$	$	$	$ 75,000.00
b. Fringe Benefits	24,195.00				24,195.00
c. Travel	4,500.00				4,500.00
d. Equipment					
e. Supplies	7,840.00				7,840.00
f. Contractual	888,465.00				888,465.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. SM-23-015 CCBHC Planning Grants	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. SM-23-015 CCBHC Planning Grants	$ 0.00	$ 0.00	$ 0.00	$ 0.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Iowa Department of Human Services

UEI: Q7P9B28J8BY4

* Street1: 1305 E. Walnut St.

Street2:

* City: Des Moines County: Polk

* State: IA: Iowa

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 50319-0114 * Project/ Performance Site Congressional District: IA-ALL

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

OMB Number: 4040-0019
Expiration Date: 02/28/2025

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

SM-23-015

CFDA(s)

93.829

Applicant Name

Iowa Department of Human Services

Descriptive Title of Applicant's Project

Iowa CCBHC Planning Grant

Project Abstract

The Iowa Department of Health and Human Services (Iowa HHS) is proud of the behavioral health (BH) services offered to our residents, but we recognize the need to expand comprehensive, person-centered, trauma-informed, and evidence-based care to Iowans who experience BH conditions, particularly those with the most serious BH needs. Under our project titled the Iowa Certified Community Behavioral Health Clinic (CCBHC) Planning Grant, and through our participation in the CCBHC Demonstration Program, Iowa will certify and reimburse eligible clinics that serve individuals with BH conditions, including individuals with Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and significant Substance Use Disorders (SUD). Certified CCBHC will be available to serve Iowa's residents who have a BH need, including an estimated 573,500 with Any Mental Illness and 248,000 with a SUD. Iowa HHS is committed to ensuring access to culturally competent services for members of historically underserved and marginalized groups, as well as members of groups experiencing poor behavioral health outcomes, including youth and adolescents experiencing SED and substance use (SU) conditions, adults with SMI and/or significant SUD, pregnant and parenting women, and veterans.

While Iowa HHS is very proud of the service delivery systems we have built, and our success in weaving those service delivery systems together, we recognize that significant barriers remain that prevent Iowans from achieving optimal health outcomes. Both stakeholders and data analyses point us to vulnerable communities and priority populations that have the greatest needs for increased capacity and access. Iowa HHS will leverage the CCBHC initiative to promote further integration and alignment with the healthcare delivery system, increase the system's capacity to offer evidence-based practices, and standardize service delivery.

The CCBHC stakeholder engagement, technical assistance, learning community, and certification readiness activities will aid in improving outcomes for CCBHCs and their Designated Collaborative Organizations. We will support our provider community as they implement the cultural, procedural, and organizational changes necessary to become CCBHCs and deliver high quality, comprehensive, person-centered, and evidence-based services that are accessible to the populations of focus. This will require us to assist CCBHCs with improving the cultural diversity and competence of their workforce by recruiting from the populations of focus and providing evidence-based resources and supports to promote their skills and build career ladders. The process of developing the initiative and preparing providers to participate in it will make it possible for Iowa HHS to build the capacity of our providers, and the accountability CCBHC funding will make it possible for Iowa HHS to ensure that the additional capacity is targeted at the needs of our priority populations. In doing so, CCBHC will enable Iowa HHS to ensure that people with SMI, youth with SED, people with significant SUD, pregnant and parenting women, veterans, adolescents with depression and/or SUD, and historically underserved minority communities can access high quality services.

Iowa HHS will collaborate with potential CCBHCs and other state-level partners to ensure consistent, accurate, and timely collection, monitoring, and interpretation of required performance measures. The Iowa Behavioral Health Reporting System (IBHRS) will act as the primary information infrastructure for the BH data needed to report measures.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** PNF.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

A-1. The Iowa Department of Health and Human Services (Iowa HHS) is proud of the behavioral health (BH) services offered to our residents, but we recognize the need to expand comprehensive, person-centered, trauma-informed, and evidence-based care to Iowans who experience BH conditions, particularly those with the most serious BH needs. Through the Certified Community Behavioral Health Clinic (CCBHC) Planning Grant opportunity, and participation in the CCBHC Demonstration Program, Iowa will certify and reimburse eligible clinics that serve individuals with BH conditions, including individuals with Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and significant Substance Use Disorders (SUD) with an emphasis on high quality care and improved outcomes for our entire community. Iowa HHS is committed to ensuring access to culturally competent services for members of historically underserved and marginalized groups, as well as members of groups experiencing poor BH outcomes, including youth and adolescents experiencing SED and substance use (SU) conditions, adults with SMI and/or significant SUD, pregnant and parenting women, and veterans.

According to the most recent census, Iowa's population, as of 2020, was 3,190,369, a 4.7% increase from 2010. Des Moines, Iowa's capital and most populous city, is located in Polk County. Polk, the largest of the state's 99 counties, has a population of 492,401; the smallest county, Adams, has a population of 3,704[1]. Iowa's population is comprised of children under 5 years of age (5.9%), youth and adolescents under 18 years (23.1%), and adults over the age of 18 (76.8%); adults ages 65 and older comprise 17.7% of all state residents. The median age is 38.5 years. Around half of the population is comprised of females (48.8%).[1] Approximately 3.6% of Iowans identify as LGBTQI.[2]

Iowa's median household income is $61,836 and the poverty rate is 11.2%, which is comparable to the national average. A majority of Iowans live in urban communities (64.3%), while about a third live in rural settings (35.7%). Civilian veterans comprise 7.6% of Iowan's adult population.

8.4% of Iowans speak a language other than English at home. Approximately 5.4% of state residents were born outside of the United States. The five predominant ethnic and racial groups are White alone/not Hispanic or Latino (84.1%), Hispanic (6.7%), Black or African American (4.3%), Asian (2.8%), and two or more races (2.1%). In 2017, the estimated number of American Indian/Alaska Natives (AI/AN) living in Iowa was 16,222, representing 0.4% of the state's population.[3] In Iowa, the federal government recognizes the Sac & Fox Tribe of the Mississippi, also known as the Meskwaki Nation, with approximately 1,450 tribal members.[4]

Iowa's prevalence of Adults with Any Mental Illness (AMI) is slightly lower than national average, with 18.5% of its adult population reporting mental illness. 44.2% of Iowans living with AMI received needed care.[5] 4.94% of Iowan adults report suicidal thoughts, higher than the national average of 4.58%.[6] In 2019, there were more than 600 violent deaths involving Iowa residents, 82.1% of which resulted from suicide; males accounted for 82% of deaths from suicide. Iowa's suicide rate of 16.2 per 100,000 residents was higher than the national average of 14.5.

Rates of SUD in Iowa are higher than the national average, with 8% of adults reporting substance use and alcohol use disorders.[7] Iowa ranks 8th in the nation for alcohol binge drinking and 5th for pain reliever misuse among adults.[8] Iowa's overdose death rate is rising faster than all but three other states; between 2019 and 2020 drug overdose deaths rose by 19%.[9]
According to the National Alliance on Mental Illness (NAMI), one in five children, or 5,500 youth in Iowa, will experience a diagnosable mental health (MH) issue, and one in 10 children, more

[1] All references and citations can be found in the endnotes included as an attachment to this application.

than 2,700 children, will experience a SED.[10] When surveyed, more than 20% of the 367,700 youth ages 12-20 residing in Iowa reported alcohol use in the prior month.[11] In 2021, 11.29% of youth ages 12-17 reported marijuana use, and 3.63% of youth report misusing pain relievers.[12] In the same year, 3.23% of Iowa youth met the criteria for Illicit Drug Use Disorder (IDUD) and 2.02% met the criteria for Alcohol Use Disorder (AUD).[13]

A-2. According to NAMI, 42.4% of adults in Iowa reported symptoms of anxiety or depression in 2021 and 25.4% were unable to obtain needed counseling or therapy. Iowans continue to struggle to secure the help they need. Of the 154,000 adults in Iowa who did not receive needed MH care, 29.3% did not obtain care because of the cost. Based on residents' poor BH outcomes, Iowa HHS selected the following Populations of Focus (POF) for our CCBHC planning activities:

Populations of Focus (POF)
Pregnant women and alcohol/substance use
Maternal BH issues are a significant cause of complications in pregnant and postpartum women. In Iowa, 24% of new mothers report sometimes or often feeling depressed since giving birth.[14] There has a been a significant increase in poor maternal outcomes, illnesses and deaths related to substance use in pregnant women, and substance use has become a leading cause of maternal death.[15] In Iowa, between 2019-2020, 26% of women of childbearing age (ages 18-44) reported binge drinking or heavy drinking.[16] In 2018, 2.8% of newborns per 1,000 hospitalized infants were diagnosed with neonatal abstinence syndrome (NAS),[17] and from 2009 through 2014, the rate of newborn in utero substance exposure increased 126% from 3.0 for every 1,000 live births to 6.6 per every 1,000 live births in Iowa. The predominant rankings of diagnostic codes for newborn in utero exposure to opioid and other substances are Drug Withdrawal Syndrome in Newborn (45.4%), Narcotics affecting fetus or newborn (27%), Noxious Influence on Fetus: Cocaine (27%), Unspecified noxious substance affecting fetus or newborn via placenta or breast milk (12.3%), and Alcohol Affecting Fetus or Newborn (4.7%).[18]
Veterans
More than 7% of Iowan adults have served in a branch of the US Military. 6% of veterans in Iowa live in poverty with an unemployment rate of 3.3%.[19] Veterans, particularly those who experienced active combat or served overseas, experience higher rates of BH symptoms than their civilian counterparts. Veterans experience significantly higher rates of Post-Traumatic Stress Disorder (PTSD) (11-20%) than the general population.[20] While the rate of depression is not significantly different for veterans then the general population, subsets of veterans including women, younger service members, those with lower ranks, and military personnel who served in Iraq and Afghanistan, may experience more symptoms of depression than their civilian peers.[21] These data are consistent with utilization trends in Iowa. Of 206,430 veterans living in Iowa in 2017, only 98,809 were enrolled in VA and 70,860 unique individuals received medical care in the VA system.[22] These data suggest that nearly half of Iowa veterans eschew care or seek services outside of the VA.
Adolescents: Depression and Substance Use
23.1% of the state's population are children under the age of 18. The 2021 Iowa Youth Survey found that between 27% to 36% of students felt "sad or hopeless almost every day" for two continuous weeks or more that they stopped participating in usual activities. Between 17% and 24% of respondents reported suicidal ideation, and, of those with a history of suicidal thoughts, between 47% to 49% of students reported a suicide plan. Between 4% and 5% of total participants reported a suicide attempt in the prior year. Rates of suicidal ideation were significantly higher among students identifying as LGBTQI (67%) than heterosexual and gender conforming students (24%).[23] Rates of depression for Iowa youth ages 12-17 are higher than the national average.[24] Data from the Iowa Poison Control Center (IPCC) show 56.4% of cases involved people under the age of 19. During the coronavirus pandemic, the IPCC saw an increase in suicide attempts via self-poisoning in tween and teen girls.[25] Despite the prevalence of BH conditions among Iowan youth, there is a scarcity of specialized professional BH services for children and adolescents. Only 36 of 99 counties have psychiatrists, an average of 1.32 psychiatrists per 10,000 children. Fewer than half of Iowa counties have psychologists, with an average of 3.06 psychologists per 10,000 children ages 0-17 years. The presence of licensed social workers with Iowa is slightly stronger; 78 counties have licensed social workers with an average of 12.28 licensed social workers per 10,000 children ages 0-17 years.[26]
BIPOC and Underrepresented Populations

Limited data on the prevalence of BH needs is available for black, indigenous and other people of color (BIPOC) in Iowa. While the lack of data leads to a limited understanding of prevalence, the challenges these communities face are clear. The presence of cultural stigmas in addition to the discrimination or harassment that these groups might encounter are considerable barriers that must be addressed through targeted approaches.

- ***BIPOC:*** BIPOC populations have BH needs at similar rates as white Americans. Their access to treatment, however, is very different. Even when care is accessible, it is not always culturally competent. BIPOC Americans have less access to MH care, are less likely to get needed treatment, and are more likely to delay care or not seek it at all.[27] Adults of color, women, and low-income Iowans report higher rates of childhood trauma compared to other racial and socio-economic groups.[28] When it comes to access to care, Black Iowans are much less likely to access services when needed; only 1 in 3 receives MH care when needed.[29]
- ***Native American & Tribal Populations:*** The Native American population in Iowa has higher rates of uninsurance (18.1% compared to the state rate of 5.0%), poverty (31.7% compared to the state rate of 11.2%), unemployment (8.8% compared to the state rate of 4.9%), and disability (24.0% compared to the state rate of 11.8%).[30] The Indian Health Services notes that AI/AN people have long experienced worse health status compared with other Americans.[31]
- ***LGBTQ & Transgender:*** 3.6% of adults in Iowa are LGBTQ and there are 106,000 residents of Iowa over the age of 13 identifying as part of the LGBTQ community, indicating a need for services both for youth and adults.[32] LGBTQ Iowans, particularly transgender Iowans, experience health disparities due to the system's unequal treatment of people with minority sexual orientation and gender identities. According to the National Center for Transgender Equality, 41% of Iowan respondents reported experiencing serious psychological distress and 16% indicated that a BH professional or religious advisor tried to stop them from being transgender.[33] More than half of Iowan survey respondents (57%) reported a depression diagnosis from a healthcare provider and 51% indicated receiving a diagnosis of anxiety.[34]

Serious Mental Illness (SMI)

As of 2020, more than 26,000 Iowans have a diagnosis of Schizophrenia and more than 56,000 have a diagnosis of bipolar disorder.[35] Iowa is facing a MH workforce crisis impacting the availability of community-based services for individuals with mental illness. Iowa is ranked 47th in the number of psychiatrists licensed to provide care.[36] Due to long wait times to access community-based services, individuals turn to emergency departments and inpatient services for help. Hospitals should be the last option, not the default. Individuals with SMI are more likely to experience negative outcomes such as incarceration. According to Iowa law enforcement, as many as 38% of the people incarcerated at any given time are there due to untreated mental illness and would be better served in the mental health system.[37] The Iowa Department of Corrections reported in 2017 that one-third of the prison population suffers from SMI while the total population with a mental illness represented 57% of the prison population.[38] One of the biggest drivers of emergency care in Iowa is MH and those with MH diagnoses are twice as likely to present at the ED for treatment and use eight times as many resources compared to those without concomitant MH issues.[39]

Serious Emotional Disturbance (SED)

13.31 per 1,000 of Iowa's youth were identified as having an emotional disturbance affecting their educational performance.[40] About 42,000 children ages 9-17 have an SED.[41] In Iowa, suicide is the second leading cause of death in youth and young adults and is higher than the national average.[42] Currently, there are only 31 child psychiatrists in Iowa ranking Iowa 47th for available psychiatrists and 44th in MH workforce availability nationally.[43] 46.5% of adolescents with emotional or behavioral problems for whom treatment or counseling is needed had difficulty accessing care. ED visits for youth with SED increased 24% for children aged 5-11 and 31% for those aged 12 to 17.[44] Our ability to meet the needs of youth with SED has decreased significantly; in 2015 Iowa was ranked 4th. Today we rank 31st.[45]

Substance Use Disorder

Iowa has a higher prevalence of SUD (15.73%) compared to the national average (13.35%).[45] The number of deaths involving Opioids has increased 88.3% since 2018.[46] Iowa has experienced a resurgence of opioid-related overdose deaths during the pandemic, increasing 32% in the first three quarters of 2020.[47] Iowa has historically limited the impact of SUD, with one of the country's lowest overall rates of drug overdose deaths, but in 2019, Iowa's overdose death rate was the 4th highest in the country.[48] Since 2020, fentanyl has become the state's more prevalent problem. Drug overdose deaths increased 20% in 2020.[49] A significant concern for Iowa is the mixing of drugs like methamphetamine and fentanyl in addition to the use of opioid drugs, including prescription medication and illicit street drugs. Opioid-related deaths increased nearly 36% in 2021, the second straight year overdose related deaths

increased for the state.[50] Iowa's opioid-related overdose deaths may have been even greater in number, if not for naloxone. Naloxone administrations by Emergency Medical Services (EMS) personnel increased significantly from 2016 (304 administrations) to 2020 (2,760).[50] Access to treatment for all SUD needs remains a problem for the state, with treatment centers concentrated in urban areas, while rural parts of the state have few addiction treatment professionals or organizations dedicated to meeting SUD needs.[51] Youth are extremely underserved in Iowa, especially in rural areas, where more than 7,000 children and adolescents do not receive the addiction treatment they need.[52] Medication Assisted Treatment (MAT) follows a similar pattern with densely populated areas able to better access treatment compared to rural areas. Only 15.4% of Iowa's rural counties have at least one provider certified to prescribe buprenorphine.[53] The majority (86.6%) of people living with Opioid Use Disorder (OUD) are not receiving evidence-based MAT treatment and the largest treatment gap identified exists in Iowa (97.3%).[54]

A-3. How BH services are organized. The Iowa system of MH and SUD services for adults and children with mental illness and/or SUD is managed and funded in various ways depending on an individual's income, insurance coverage, and service needs. The Iowa Department of Human Services (DHS), the State Mental Health Authority (SMHA) and State Medicaid Agency (SMA), and the Iowa Department of Public Health (IDPH), the Single State Agency (SSA), have aligned to form Iowa HHS. All three authorities required for execution of the CCBHC planning grant are now housed within Iowa HHS effective July 1, 2022. DHS, the legacy SMHA, is the applicant agency for this project as business operations continue to be fully transitioned to Iowa HHS. Throughout this application DHS will be referred to as Iowa HHS. This alignment effort brings the three state-level authorities together under the leadership of Director Kelly Garcia and includes the SMHA and the SSA within the Division of Behavioral Health and Disability Services (BHDS).

Authority	Iowa HHS Location	Activities
State Mental Health Authority	Iowa HHS BHDS, previously the DHS Division of Mental Health and Disability Services, (MHDS) administers MH services	BHDS is the state MH authority (SMHA) in Iowa and is responsible for 14 MHDS regions, accreditation of community mental health centers (CMHCs), mental health service providers (MHSPs), crisis service providers, and certain non-behavioral health service providers. There are 14 MHDS Regions that manage and oversee delivery of required core adult and child services and evidence-based practices. Regions also work with Iowa Medicaid to monitor network adequacy.
Single State Agency	Iowa HHS BHDS, previously the IDPH Division of Behavioral Health, administers SUD services.	BHDS is responsible for licensure of all SUD treatment programs, and for administration of state SUD appropriations and the Substance Abuse Prevention and Treatment Block Grant. BHDS manages the Integrated Provider Network (IPN) to increase access to SUD services. SUD providers must be licensed by Iowa HHS to provide SUD services in Iowa.
State Medicaid Authority	Iowa HHS Medicaid	Medicaid services, including services for MH/SUD, are administered by Iowa Medicaid.

How BH services are funded:

Medicaid and Children's Health Insurance Plan	Delivers MH/SUD services through a comprehensive managed care model or fee-for-service, depending on the population. The plan includes 3 1915 waivers that include BH services including a 1915i Habilitation waiver, and an 1115 Demonstration waiver for Medicaid Expansion services.
State General Fund Appropriation and Substance Abuse Block Grant (SABG)	IPN services are funded by the State General Fund appropriation to Iowa HHS for substance abuse and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA SABG. IPN funding may be used to pay for treatment covered services that are not covered under the Iowa Health and Wellness Plan (the Medicaid Expansion Program), specifically, residential treatment. IPN funding may also be used to pay for treatment services that are not covered during the gap period between enrollment in Medicaid and assignment to a managed care organization (MCO).

State Allocation for MHDS Regions	The MHDS regions, the MCOs, and Iowa HHS work collaboratively to ensure that all services that are Medicaid-reimbursable are billed, preserving legislative allocations for regional funding for services and individuals not covered by Medicaid.
Department of Education (DoE)	Beginning in 2021, the Iowa DoE initiated competitive grant awards to school districts to establish therapeutic classrooms for learners whose social-emotional or behavioral needs impact their ability to be successful in their learning environment. The Therapeutic Classroom Incentive Grant was established through state legislation signed into law in 2020 and is part of a statewide effort to increase MH supports for children, youth and families.
Mental Health Block Grant (MHBG)	State legislation directs Iowa HHS to distribute 70% of the MHBG to CMHCs to be used for staff training for evidence-based practices or services for adults with an SMI, children with a SED, and individuals with co-occurring conditions. MHBG funds are also used for projects of statewide significance including First Episode Psychosis, Systems of Care, Peer-operated organizations and peer training, Center of Excellence for Behavioral Health, 988 and Your Life Iowa (crisis services), and Project Recovery Iowa (COVID-related MH counseling).
Additional Funding	HHS receives the following appropriations/grants that support Iowa's opioid initiatives: Iowa General Fund Appropriation, SAMHSA State Opioid Response Grant, SAMHSA Strategic Prevention Framework – Prescription Drugs Grant, CDC Strategic Initiatives to Prevent Drug Overdoses, CDC Opioid Overdose Crisis Cooperative Agreement for Emergency Response, CDC Overdose Data to Action, SAMHSA Prevention of Opioid Misuse in Women, SAMHSA First Responders Comprehensive Addiction and Recovery Act. Additionally, many BH provider organizations fund their services through federal, state and local grant awards. Funding sources include United Way and local foundations.

How BH services are provided:

Community Mental Health Center (CMHC) and other Mental Health Service Providers
CMHCs and other MH service providers are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 23 CMHCs providing MH services to adults and children. Approximately 74 other agencies are accredited as MH Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHCs receiving MHBG funding, Iowa Medicaid sets MH network adequacy standards.
Integrated Provider Network (IPN) and other Substance Use Providers
Iowa HHS contracts with 20 competitively procured local IPN agencies to provide problem gambling, prevention, treatment, and recovery support services in 19 service regions that serve all 99 counties. IPN supports services for Iowans without insurance, Medicaid, or other payment resources. HHS Medicaid also enforces network adequacy standards to assure access to SUD services, beyond those available through procured IPNs.
Federally Qualified Health Centers (FQHC)
Iowa has 72 FQHC sites enrolled as Medicaid providers. FQHCs also provide screening and referral to behavioral health (BH) services and in some instances, provide direct BH services. Other MH providers have collaborative relationships with FQHCs to facilitate access to integrated health and BH care.
Health Homes
Iowa has two Health Home Programs. **Chronic Condition Health Home:** Primary care providers enroll members that have one chronic condition and the risk of developing another, which includes a MH or SUD condition. **Integrated Health Home (IHH):** Iowa currently has 39 IHHs for those with SMI or SED. Services include Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, Referral to Community and Social Support Services.
CCBHC-Expansion Grantees (CCBHC-E)
Iowa has 14 CCBHC-expansion grantees, 5 of which were not awarded a new round of funding in 2022, and 2 which are new grantees in 2022.
Crisis Providers

Iowa has 8 Access Centers, designated by each of the 14 MHDS Regions to provide assessment, MH/SUD and suicide screening, crisis stabilization, subacute services, SUD services, psychiatric evaluations, counseling services and peer support services, additional resources and referrals. **Iowa has a total of 13 adult and 7 child crisis stabilization residential providers. Iowa has 13 state-sanctioned Mobile Crisis response providers** covering 12 regions and 85 of 99 counties. **Your Life Iowa** is the Statewide Crisis Line. Iowa has **two 988 Crisis Centers** covering the entire State for crisis call, text, and chat.
Inpatient Psychiatric Care And MH/ SUD Residential Care
Mental Health Institutes (MHI). Iowa HHS oversees two MHIs, located in Cherokee and Independence. The MHIs provide critical access to quality acute psychiatric care for adults and children needing mental health treatment. The MHIs are licensed as hospitals with 64 adult and 28 child/adolescent beds across the state.
Inpatient Psychiatric Facilities. There are 24 hospitals in Iowa which have licensed inpatient psychiatric units serving children and adults with a total licensed capacity of 828 beds. Two are freestanding inpatient psychiatric hospitals and 22 are specialized psychiatric units in general hospitals. Total staffed bed capacity is 599: 430 adult beds, 72 older adult beds, and 97 child beds.
Residential Care Facilities for Persons with a Mental Illness. The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for Persons with a Mental Illness (RCF/PMI). Eight programs, with 10 locations and 135 beds are currently licensed.
SUD Adult and Juvenile Residential Treatment Facilities. IPN Providers have the option to provide residential treatment to adults and/or juveniles, which must include 1 or more ASAM levels of clinical management and/or medical monitoring (ASAM Levels 3.1, 3.3, 3.5, and/or 3.7). Residential facilities must also provide or connect individuals to early intervention (for problem gambling), MAT services, recovery peer coaching and family education services. There are currently 12 adult and 3 juvenile licensed facilities in the state.
Intermediate Care Facilities for Person with Mental Illness. DIA also licenses Intermediate Care Facilities for persons with mental illness (ICF/PMI). They may participate in Medicaid as a Nursing Facility for Persons with Mental Illness (NFMI). Medicaid will only fund persons 65 and over in this setting. Currently there are 3 Iowa facilities that hold this licensure with a capacity of 109. MHDS regions may pay for this level of care for individuals who are not eligible for Medicaid funding.
Psychiatric Medical Institutions for Children (PMIC) (also known as Psychiatric Residential Treatment Facilities (PRTF). These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home community. There are 8 private agencies that operate 378 Medicaid-funded beds. 30 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs.

A-4. Medicaid State Plan Coverage. All required CCBHC services are covered under the Medicaid State Plan. Targeted Case Management is provided under IHH for those with a MH primary diagnosis or co-occurring MH/SUD; SUD as sole primary diagnosis is not covered. **1115 Demonstration Coverage** includes most services for those age 19-64 only. Excluded services consist of crisis residential, treatment planning, targeted case management, and peer, family support & counselor services; however, those who are medically exempt can access these services.

A-5. Current Medicaid payment and service delivery system: Under Iowa's **Medicaid State Plan,** Iowa HHS administers BH services under four waivers and the Affordable Care Act (ACA):

1915b Managed Care	**IA Health Link** operates service delivery and reimbursement under a risk based Managed Care Organization (MCO) model. Most services are included in this statewide MCO structure, including long-term services and supports (LTSS), BH, and pharmacy, delivered in a coordinated manner. Approximately 93% of all Iowa Medicaid members are enrolled in an MCO with 7% in Fee-For-Service (FFS). Iowa's **Hawki** population (CHIP - Children ages 0-18) is served by the same MCOs and included in the total MCO population. Iowa is currently operating the IA Health Link program with two MCOs: Amerigroup Iowa, Inc. (Anthem/Elevance) and Iowa Total Care (Centene). Molina joins the market effective 7/1/23.

1115 Waiver	The **Iowa Health and Wellness Plan (IHWP)** is the State's Medicaid Expansion program for adults ages 19-64 with incomes up to and including 133% of the FPL who are not otherwise eligible for Medicaid or Medicare
Fee for Service	Medicaid operates a limited FFS program for members not enrolled in managed care.
1915c HCBS Children's Mental Health Waiver	Provides children with SED services that can enhance traditional services to develop a comprehensive support system. Services include environmental modifications and adaptive devices, Family and community support services, In-home family therapy, Respite.
1915i Habilitation Services	Habilitation services are available for individuals who experience functional limitations typically associated with chronic mental illness.
Health Homes	The Health Home Delivery model supports members with qualifying conditions with access to an inter-disciplinary array of medical care, BH care, and community-based social services and supports for both children and adults.

Iowa Medicaid is a major source of funding for BH in Iowa. Medicaid's managed care contractors are required to provide high quality healthcare services in the least restrictive manner appropriate to a member's health and functional status. Contractors are responsible for delivering coordinated services including physical health, BH, and LTSS. IHWP and Hawki members have a more limited set of BH benefits; IHWP members can access full Medicaid benefits through a medical exemption determination. Hawki youth may be eligible for Medicaid benefits based on identification of SED-related need via the Children's MH waiver or Medicaid for Kids with Special Needs. Medicaid coverage for residential care is triggered by long-term residential stays; this coverage is not applicable to SUD residential treatment due to separate licensure.

Components that will enhance CCBHC services listed in the Certification Criteria:

Commitment to integrated BH care for all populations, including complex individuals with medical diagnoses.
The alignment of DHS and IDPH demonstrates Iowa's commitment to dissolving silos to create a unified, integrated system that oversees the full range of BH services; improves access to services; eases system navigation for Iowans; and aligns health and human services policy that drives improved integrated outcomes. The alignment will also facilitate a more efficient and coordinated state implementation of the CCBHC demonstration.
Strong existing framework/infrastructure on which to build statewide CCBHC model.
Since our last planning application, Iowa has initiated a set of system transformation initiatives that have strengthened and enabled the system to adapt to CCBHC. Iowa has a nucleus of 14 CCBHC-Es, all of which are valued as key stakeholders and advocates for advancing the delivery of BH services through innovative practices and shared lessons in the CCBHC model. Many CCBHC-Es are CMHCs and SUD providers: this blend of programming and service delivery establishes an experiential foundation on which to build. Iowa providers understand how to implement CCBHC requirements and tailor them to population needs and complement Iowa programs. Iowa's MHDS regional structure has matured over the last 8 years, facilitating access to an expanded set of MH services including children's services. The regional structure is now a more uniform, statewide approach that includes performance-based contracts. The regional structure provides infrastructure for the statewide crisis response system. The Iowa Center of Excellence for Behavioral Health (CEBH) was developed in April 2022 through a procurement process. The CEBH provides training, technical assistance, and fidelity monitoring for providers and funders of Assertive Community Treatment, Individual Placement and Support, and Permanent Supportive Housing. The CEBH provides HHS with recommendations for additional evidence-based practices to address gaps in Iowa's BH system.
Existing statewide data, quality, oversight, reporting system that is capable of advancing goals tied to continuous quality improvement and outcomes monitoring in a CCBHC demonstration.
Iowa implemented the Iowa Behavioral Health Reporting System (IBHRS) in 2021 to fulfill the integration of licensure and data reporting requirements for IPN providers delivering services through the SABG. IBHRS will serve as the backbone for CCBHC performance oversight and will enable ongoing analysis of cost savings.
History of deploying Prospective Payment Systems (PPS) successfully for FQHCs

Iowa has a strong history of reimbursing eligible providers under a PPS. Iowa Medicaid is committed and capable of implementing PPS under a demonstration model for eligible, certified CCBHC providers.
History of stakeholder collaboration and opportunities for community input to inform State efforts.
Iowa values stakeholders as integral to state system transformation efforts; their feedback informed the development and ongoing evolution of the MHDS Regions, implementation and development of 988, and the state's prior CCBHC demonstration application efforts. CCBHC stakeholders include: Individuals with lived experience and their family members, Department of Veteran Affairs, Coalition for Family and Children's Services, Iowa Board of Health, MH Planning and Advisory Council, Iowa BH Association, Iowa Association of Community Providers, and Iowa Hospital Association.

There are no components of the Iowa Medicaid payment and service delivery system authorities for BH that will inhibit CCBHC services listed in the Certification Criteria. We do, however, recognize and expect complexities with statewide CCBHC implementation stemming from the way Iowa has historically organized and paid for BH services. For example, we are proposing a catchment area model for distribution of CCBHCs which will allow Iowa HHS to realign the distribution of BH services to better serve the needs of populations throughout Iowa. This realignment could potentially disrupt legacy BH providers and will require careful planning and implementation from the entire Iowa HHS team to ensure individuals retain access to critical BH services and existing providers remain valued partners in the BH system. We also recognize the complexity of the CCBHC payment model design, including deployment of PPS. Iowa HHS will need to implement payment in consideration of the existing funding models that include a variety of funding sources described earlier in this section to ensure compliance, program integrity, and financial efficiency. We will dedicate planning grant resources and design our stakeholder engagement to inform these decisions and ensure a sound implementation approach that supports access to sustainable BH services, comprehensively across areas of need in Iowa.

B-1. While Iowa HHS is very proud of the service delivery systems we have built, and our success in weaving those service delivery systems together, we recognize that significant barriers remain that prevent Iowans from achieving optimal health outcomes. Both stakeholders and data analyses point us to vulnerable communities and priority populations that have the greatest needs for increased capacity and access. Iowa HHS will leverage the CCBHC initiative to promote further integration and alignment with the healthcare delivery system, increase the system's capacity to offer evidence-based practices, and standardize service delivery. We will focus especially on individuals with the most complex conditions and populations who have been historically underserved including BIPOC and immigrants. In addition, we will create regulatory and payment model incentive structures to ensure focus on youth, pregnant and parenting women, and veterans. By utilizing a catchment area model, we will ensure accountability for reaching the communities most in need and offering them care that is culturally and linguistically appropriate.

The CCBHC stakeholder engagement, technical assistance, learning community, and certification readiness activities will aid in improving outcomes for CCBHCs and their DCOs. We will support our provider community as they implement the cultural, procedural, and organizational changes necessary to become CCBHCs and deliver high quality, comprehensive, person-centered, and evidence-based services that are accessible to the populations of focus. This will require us to assist CCBHCs with improving the cultural diversity and competence of their workforce by encouraging recruitment from the populations of focus and providing evidence-based resources and supports to promote their skills and build career ladders. The process of developing the initiative and preparing providers to participate in it will enable Iowa HHS to build the capacity of our providers, and the accountability CCBHC funding will make it possible for Iowa HHS to ensure that the

additional capacity is targeted to the needs of our priority populations. In doing so, CCBHC will enable Iowa HHS to ensure that people with SMI, youth with SED, people with significant SUD, pregnant and parenting women, veterans, adolescents with depression and/or SUD, and historically underserved minority communities can access high quality services.

Service or service aspect	Capacity	Access and availability
Crisis services	While most regions of the state have access to crisis services, there are areas where the full array of crisis services are not available, and individuals rely on 911 and hospital emergency departments for crisis services. In addition, many mobile crisis services do not offer naloxone or on-demand Buprenorphine induction. The planning for the CCBHC initiative will enable Iowa HHS to develop an integrated system of crisis services that is broad enough to meet the needs of our entire population, yet sufficiently integrated into the fabric of the community to permit providers to develop the linguistic and cultural capabilities that will enable all Iowans to receive crisis care that is comprehensive (including providing Narcan and on-demand MAT induction) and culturally competent.	Crisis services in Iowa are not universally available 24x7x365 and, in some communities, access within two hours is not available. The current crisis service delivery system is not coordinated across jurisdictions, leaving teams unable to effectively provide redundancy. The coordination, service expansion, and imposition of the CCBHC access standards will enable Iowa HHS to ensure that every Iowan has access to reliable, high quality 24x7x365 mobile crisis service in under two hours. In addition, by integrating 988, we will make crisis support universally and easily accessible, as well as enable teams to back each other up and provide redundancy. Through CCBHC people with SMI; youth with SED, depression, and SUD; veterans, and historically underserved communities will be able to access crisis services in any part of the state at any time.
Screening, assessment, and diagnosis	The BH demand increase due to COVID-19 and the concomitant workforce crisis have led to increasing waits for intakes and diagnostic assessments. This problem is especially acute for people with limited English proficiency who prefer an assessment in another language. Primary care providers are less likely to screen when there are delays in access to services, which may cause significant unnecessary suffering. Our delivery systems have simply not been able to keep up with the need, and the outcomes are seen in suicide and overdose rates that are moving in the wrong direction. These connections will be especially valuable for pregnant and parenting women and veterans whose medical and behavioral health needs are deeply intertwined. In addition, CCBHC funding will enable providers to develop the needed capacity to provide screening, assessment, and diagnosis in languages other than English and with sensitivity to unique cultural needs and understandings of illness.	The CCBHC access standards will enable Iowa HHS to hold providers accountable for providing timely and comprehensive intakes. This will ensure that Iowans in every catchment area – regardless of their linguistic needs – are able to get assessments and diagnoses timely. Solving that will enable primary care providers and OB/GYNs to expand their screening and referral processes. Similarly, reimbursement for primary care screening in BH settings has not been sufficient to enable providers to develop comprehensive primary care screening and monitoring programs. The CCBHC-related program expansions will enable the development of this screening capacity within the BH delivery system which will be particularly valuable for people with SMI, youth with SED, and people with significant SUD who primarily get care from the BH delivery system.
Patient-centered treatment planning	Treatment planning requires an interdisciplinary team to collaborate with a client and his/her family to develop a plan that is individual-centered, culturally appropriate, and trauma-informed. Few Iowa BH provider agencies have the capacity to regularly hold	By establishing catchment areas that provide accountability for the availability of timely team-based treatment planning, Iowa HHS will be able to ensure that all Iowans can access individual-centered treatment planning. In addition, the triennial CCBHC planning process

	the type of team meetings that enable comprehensive treatment planning. The PPS model will account for these costs and enable providers to dedicate staff time to developing the most appropriate plan possible in collaboration with individuals. The team-based treatment planning enabled by CCBHCs will be especially important for the most complex clients, those with SMI, SED, significant SUD, COD, and medical comorbidities.	will ensure that BH providers stay connected to the changing demographics and needs of their communities and develop treatment planning processes (and treatment services) that meet the unique needs of their community, including specific programs for immigrant and minority populations that are concentrated in specific parts of the state as well as for veterans who choose not to access services from the VA.
Outpatient mental health and substance use disorder services	Iowa has developed a system of CMHCs and IPNs that provide care but does not have the capacity to serve everyone in need and offers integrated care for people with co-occurring disorders in only some communities. The CCBHC application and certification process will enable us to develop comprehensive outpatient behavioral health care that has the capacity to serve Iowans with all levels of BH acuity in every community in the state. This will be especially important for historically underserved communities that the system has lacked the capacity to serve with culturally competent services.	In recent years the availability of intensive outpatient community-based behavioral healthcare has contracted, forcing more Iowans into inpatient and residential settings. This problem has been especially acute for youth. The CCBHC-related capacity growth will enable providers to expand their offering and effectively serve people who need care that is outpatient, but still intensive and extensive, especially people with SMI, youth with SED (including major depression), and people with significant SUD. This will be essential for people with co-occurring psychiatric and addictive disorders who currently lack access to integrated care, as well as for youth with SUD who frequently need extensive support.
Targeted case management	Most Medicaid recipients in Iowa who have behavioral health disorders lack access to Medicaid-funded case management. IHH care coordination is available, but underutilized, to Medicaid recipients with primary diagnosis of SED or an SMI who also display functional need and meet all other financial and need based eligibility criteria. Intensive care coordination is provided via the IHH model for children on the children's mental health waiver and adults receiving 1915i and state plan habilitation. Medicaid-eligible Iowans who are enrolled with an MCO who do not meet the eligibility threshold for IHH have access to MCO care management, which is often short term, medical model, and telephonic. Individuals with co-occurring needs which may include SMI, SED and/or SUD who are also eligible for funding under one of Iowa's seven 1915(c) waivers are provided with Community-Based Case Management via the MCO or, if enrolled in FFS Medicaid, case management or Targeted Case Management through Iowa HHS or another Medicaid-enrolled Case Management provider. The CCBHC PPS process, although it won't pay for case management as a service, will enable providers to include their case management	The extant case management services are accessible to some Iowans, either through Medicaid or the regions, which fund case management for some non-Medicaid eligible people. This has left a patchwork system of uneven access and required those providers who can offer case management to triage it to only the most acutely ill individuals who can meet eligibility thresholds. As a result, non-waiver eligible individuals who do not need Long Term Services and Supports, but do need case management (e.g., individuals leaving correctional settings) and individuals with SUD lack access to care management. This has left many individuals and their families struggling with the complexities of the service delivery system on their own. This is especially problematic for people with limited English proficiency, including immigrants, who can find accessing the system overwhelming. Culturally sensitive case management will be especially valuable for those populations. Similarly, pregnant, and post-partum women and their children will benefit from case management that engages them in BH care. While most Medicaid members with SMI currently have access to case management through this patchwork, the enhanced access and availability will be particularly important for pregnant and

	costs in a PPS rate. This financial support will Iowa to re-examine the fractured delivery model and align delivery to the needs of Iowans.	parenting women, veterans, people with SUD, and adolescents with depression, who currently lack consistent access.
Psychiatric rehabilitation services	Iowa lacks sufficient psychiatric rehabilitation services to meet the growing need. Capacity is greatest in urban areas and for English speakers. In regions with significant numbers of people with limited English proficiency, this will enable the development of psychosocial rehabilitation services designed specifically for linguistic minorities. Iowa has 18 Assertive Community Treatment (ACT) teams but coverage is not statewide.	Our CCBHC certification process will ensure that treatment for first episode of psychosis and psychiatric rehabilitation services including ACT are accessible in every catchment area in a way that is integrated with the intensive clinical and social services that are essential to the recovery of people with serious mental illness, youth with SED, and people with significant SUD.
Peer support and counselor services and family supports	CCBHC Expansion grantees in Iowa have used their grants to expand the use of peers, particularly for outreach and engagement. HHS is committed to using the CCBHC initiative to expand the capacity of peer and family support services into every community in the state. The most effective peer support is provided by someone who not only shares a diagnosis, but also a perspective with the individual. For Hispanic, African, and African American Iowans, a peer who shares their experience of America, speaks their language, and comes from their culture will be a new capacity for the BH system that has the potential to support recovery in powerful ways. Iowa HHS will utilize the CCBHC PPS process and the Quality Bonus Payment (QBP) to incent the addition of peers, especially culturally specific peers.	Access to peer and family supports will be improved across Iowa as they are integrated with the rest of the service portfolio through the CCBHC initiative. Iowa HHS already funds initial and ongoing training for peer and family peer support specialists and recovery coaches. We will further promote the use of peers by incenting CCBHCs to develop a peer and family support staff that is reflective of the demographics of the people their CCBHC serves in order to expand access to culturally appropriate support and counselor services. In addition, our planning process will emphasize the development of more youth peer advocates, in order to ensure that young people with depression, SUD, and SED have access to peer support.
Mental health care for members of the armed services and veterans	One Iowa CCBHC expansion grantee has indicated that they have tripled the number of veterans they serve because of their expansion grant. This demonstrates the size of the currently unmet demand, which has been exacerbated by a lack of military cultural competence training and poor connections between the community-based system of care and the Veteran's Administration (VA). HHS will use the CCBHC certification process to expand the community system of care's capacity to serve veterans, and to improve the collection of data so that we can understand the needs of our veteran community. During the planning grant period, we will support the development of connections between the community and VA systems and will build out plans to ensure they are better integrated.	While Iowa's population of veterans is not a large one, they are valued members of our community; we owe them access to high quality behavioral health care. Iowa HHS is committed to taking a holistic approach to the integration of the VA and the community-based system so that we can maximize on the opportunity to coordinate access for our veterans. The Iowa Department of Veteran's Affairs will be invited to join the CCBHC steering committee to ensure that connection points to the existing VA health systems are well understood and that the needs of veterans are prioritized in the development of our CCBHCs.
Outreach and engagement	Stakeholders have highlighted the need for more assertive outreach and engagement and the inadequacy of the current rate structures to support the comprehensive outreach	Currently some regions in Iowa have provided grants to community-based providers to enable them to provide outreach and engagement services. As a result, they are not available

	strategies providers want to employ. Inclusion of the costs of outreach in the CCBHC PPS will enable providers to significantly expand their capacity to provide outreach, engagement, and navigation services, particularly utilizing peers. Iowa HHS will establish a performance measurement reporting and QBP system that will incent providers to develop specific outreach programs for the populations of focus. These may be culturally/linguistically focused (i.e., Spanish or Swahili) or population-specific (e.g., pregnant women).	evenly throughout the state. Development of CCBHCs in accountable catchment areas will enable providers to do outreach and enable the state to hold providers accountable for engaging the members of their community with complex needs, especially those from our target populations. Iowa HHS recognizes that historically marginalized and non-English speaking populations are likely to require assertive and culturally specific outreach. The training, technical assistance, and funding from the CCBHC initiative will enable providers to conduct these outreach and engagement activities in diverse sites where our populations of focus may be found, including senior centers, religious institutions, community centers, parole offices, emergency departments, and other community settings.
Staff training	Training has been another area where providers have been challenged, especially as turnover has exacerbated the financial and capacity challenges associated with providing comprehensive training in Evidence-Based Practices (EBPs). Iowa HHS will identify 4-6 EBPs that all CCBHCs will be required to offer. In addition, Iowa HHS will encourage CCBHCs to select additional EBPs that are appropriate given the demographics and needs of their catchment area. In this way Iowa HHS will use the CCBHC planning, application, and certification processes to expand the capacity of our service delivery system to offer evidence-based treatment.	The enhanced training requirements to which Iowa HHS will hold providers and the cost-based reimbursement that will enable providers to provide comprehensive high quality staff training will lead to a delivery system in which citizens of every catchment area will be able to access a consistent set of EBPs implemented with fidelity to the model no matter where in Iowa they live. This will be especially important for demographic minorities (racial, ethnic, sexual orientation, gender identity) who will have access to care from providers with the specific and nuanced training that will enable providers to meet their needs with precision.
Workforce diversity	Iowa HHS's reporting requirements for CCBHCs will enable us to access the data we need to demonstrate how well the workforce in our behavioral health delivery system reflects the people our system serves. This will enable us to develop specific strategies and accountability structures for expanding our workforce to reflect our consumers.	Not all Iowans currently have access to services provided by a workforce that reflects their race, ethnicity, culture, country of origin, sexual orientation, or gender identity. Iowa HHS has designed the CCBHC initiative with catchment areas large enough to provide economies of scale, but small enough to enable community-specific initiatives. This will enable CCBHCs to recruit, train, and retain staff from the linguistic and cultural minorities in their communities.
Services that address social care needs	Iowa's commitment to integrating healthcare with services that address health related social needs is demonstrated by the enormous efforts made in recent years to integrate IDPH and DHS into a consolidated health and human services department. This amalgamation within the government will enable us to maximize on the opportunity created by the CCBHC certification requirements to integrate health, behavioral health, and human services into a more comprehensive, coordinated, and coherent service system, especially for Iowans with the	Iowa HHS envisions CCBHCs as holistic providers of comprehensive and coordinated care that identify people's need for access to health, behavioral health, and human services, and connects them to those services. With accountable catchment areas and providers who are deeply rooted in their communities, CCBHCs will serve as hubs that help to span the boundary between the healthcare and human service systems. By integrating human services into a comprehensive care process that includes the whole BH benefit and connects meaningfully to primary care, Iowa HHS will

	most complex conditions like SMI, SED, COD and SUD. The coordination of investments and oversight will enable Iowa HHS to purchase more efficiently, thus expanding capacity (especially for serving people with SMI, SED, and SUD), and spreading it across the state.	utilize CCBHCs to improve access to human services for people with behavioral health conditions. This will be especially important for pregnant/parenting women and the historically underserved populations whose health outcomes are most impacted by health-related social needs.
Cultural responsiveness	The CCBHC capacity growth and certification process will expand Iowans' access to culturally responsive care by both providing funding to enable it and regulations to hold providers accountable for providing it. In addition, CCBHCs will be able to enhance their recruitment, enabling them to hire staff who are fluent in Spanish, Swahili, Marshallese, Kirundi, and other languages spoken by the people they serve. CCBHCs will be specifically incented to report data refined by and serve our target populations to receive quality bonus payments, which will increase the capacity of the service system to meet the unique cultural needs of diverse Iowa communities.	CCBHCs will have responsibility for the whole of their catchment area, which will enable them to develop the specific culturally responsive services their community needs. The initiative will enable the collection of data that will be essential for developing new services and program models to meet the needs of Iowa's evolving demographics. Outreach, engagement, care management, treatment and peer support will be enhanced through the diverse workforce the CCBHC certification process will require, and cost-based reimbursement will enable providers to develop new services, and new capacities to respond to their community's changing needs.
Population communication needs and health literacy	Iowa HHS already supports public education campaigns about drug use, gambling addiction, mental illness, and suicide through the *Your Life Iowa.* The roll out of 988 and the CCBHC initiative will enable HHS to expand and enhance those campaigns. We will use public education to encourage people to call 988, which will serve as a vehicle to connect them to comprehensive treatment at a CCBHC. The CCBHC certification requirements and process will increase HHS's capacity to share public education campaigns and ensure that Iowans reached by them are connected to ongoing care.	A core message of the *Your Life Iowa* campaigns is that care is available for Iowans who need it. The CCBHC catchment areas and access standards will enable us to ensure that services are accessible when Iowans reach out for help. Increasing the availability of anti-stigma messages will be especially important for Iowans who are reticent to seek care, including those from cultures that are traditionally less open to outpatient behavioral health care.

B-2. Iowa HHS intends to procure a single CCBHC for each identified catchment area through a competitive process. This will enable us to have a locus of accountability for hospital discharges, correctional discharges, crisis services, and case management. We plan for procurement to happen during the third quarter of the planning grant year. Iowa HHS recognizes the complexity of CCBHCs and the level of operational capability, clinical expertise, community connection, and organizational infrastructure necessary to successfully implement the model with fidelity and quality. We also recognize that the integrated model requires that providers be capable of serving people with SMI, youth with SED and people with significant SUD with equal capability. As such, we intend to establish a high standard to be eligible to even apply to become a CCBHC.

To ensure that applicants are prepared to serve our target population, we will require that the organizations included in the application (the CCBHC and any DCOs) have at least five years' experience providing MH services and five years' experience providing SUD services. The applicant must have an existing license/accreditation/designation for either SUD or MH services (i.e., IPN designation, outpatient SUD license, CMHC accreditation, and/or Mental Health Service Provider accreditation). If they do not already have both licenses/accreditations/designations, they

must have a pending application submitted for the license/accreditation/designation they lack. To expand the potential pool of applicants, Iowa HHS is prepared to consider providers whose MH or SUD license/accreditation/designation is from out of state, but in that instance the provider must have pending applications for both a MH and SUD license/accreditation/designation in Iowa. Furthermore, we will require that all applicants are accredited by a national accrediting body such as The Joint Commission, Council on Accreditation, or Commission on Accreditation of Rehabilitation Facilities. And, because each CCBHC catchment area includes at least one county designated as rural, we will have specific procurement standards related to their presence in rural communities, and their capability to offer services tailored for rural communities.

The procurement process will be driven by the provider's ability to demonstrate compliance with all 115 CCBHC criteria related to staffing, accessibility, care coordination, quality, and organizational authority across a service portfolio that includes all nine of the required CCBHC services and Assertive Community Treatment (ACT). In their responses to the procurement, providers will have to demonstrate that they have any necessary DCO relationships in place and processes for sharing data with DCOs and ensuring their services comply with the CCBHC standards. Providers will be required to demonstrate their ability to meet all SAMHSA CCBHC certification criteria by the end of the planning grant year.

The provider's response to the RFP will serve as their initial application to participate and will be reviewed and scored to determine CCBHC certification eligibility. Once a provider is selected through this competitive process, Iowa HHS will conduct a desk audit to review all CCBHC materials, including existing licenses/accreditations/designations, policies and procedures manuals, and staff credentials. Upon successful completion of the desk audit process, providers will be preliminarily certified for an initial 270 days. This is consistent with the methodology Iowa HHS uses for SUD licensure and MH accreditation, so it is a process for which our provider community is prepared.

During the 270-day preliminary certification period, Iowa HHS will conduct an on-site audit to review electronic records, case notes, human resources files, signage, and other physical plant aspects. This on-site audit will result in de-designation if significant deficiencies are discovered, or a one-, two-, or three-year certification. If a provider's score qualifies them for a one- or two-year certification, the provider must develop a Corrective Action Plan (CAP) to address documented deficiencies. That plan must be approved by Iowa HHS and in some circumstances triggers another on-site audit. This too is consistent with the ways in which Iowa HHS has licensed and accredited BH providers in the state. Once Iowa HHS certifies a provider, that provider's CCBHC certification, and their provider-specific rate, will be transmitted to the Medicaid MCOs to modify their payment rules.

Iowa HHS has not yet certified CCBHCs. There have been 14 Iowa CCBHC-E grantees, with 2 new programs awarded CCBHC-E grants in 2022. Recognizing that we cannot certify CCBHCs unless our provider community is capable of achieving CCBHC certification, Iowa HHS intends to utilize funding from the planning grant to provide training and technical assistance to providers who are interested in participating in the CCBHC initiative whether they are expansion grantees or not. We will procure training support for learning collaboratives for providers in groupings based on their current capabilities and their intentions for becoming a CCBHC or a DCO. These trainings will emphasize the programmatic changes required to comply with the CCBHC certification criteria. We have received feedback from the existing CCBHC expansion providers about the most challenging aspects of compliance with the certification criteria and will ensure

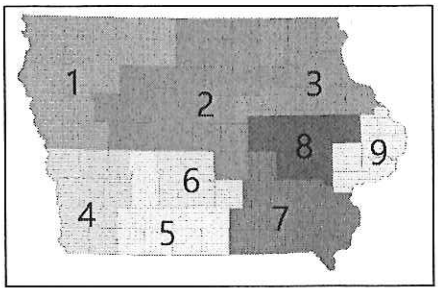
trainings address those aspects of compliance. Specific gaps they have identified include assessing gaps in staffing and services, workforce development, building partnerships and formal relationships, implementing evidence-based practices with fidelity, care coordination, performance measurement and reporting, continuous quality improvement processes, and implementing and optimizing health information technology (HIT) infrastructure. In addition, we will provide training and technical assistance on the cost reporting and PPS development process, which no Iowa providers have done yet.

Beyond the training, we anticipate that Iowa HHS staff will provide ongoing assistance to the CCBHCs once they're designated. We recognize that the CCBHC demonstration model is new to all the providers in the state, and we anticipate that they will require ongoing collaboration from Iowa HHS staff. Together we will identify their ongoing needs and challenges, and work with them to address those newly identified challenges.

B-3. 78 of Iowa's 99 counties are considered rural. We have preliminarily divided the state into nine catchment areas for CCBHCs. all nine have at least one rural county, seven have more rural counties than not, and two are entirely rural except for a single county. Two catchment areas have fewer than 1/3 rural counties. There are five cities in Iowa with populations greater than 75,000. They are spread among four different catchment areas. As such, every CCBHC in Iowa will be required to serve rural communities. One CCBHC will serve Polk County, which includes Des Moines, our largest city, the suburban counties surrounding it, and one rural county. The other CCBHCs in Iowa will have catchment areas that cover rural and non-rural areas, including four that have both rural counties and a city with more than 75,000 people.

CCBHCs will be required to provide care to the entire geography of their catchment area. Iowa HHS will develop coverage adequacy standards for CCBHCs to ensure accessibility. The nature, structure, and monitoring process for these coverage adequacy standards will be developed during the planning grant period with significant stakeholder input. In addition, we intend to deliver specific procurement standards related to their accessibility to rural communities, and their capability to offer services that are culturally appropriate for, and accessible to, rural communities. In this way, Iowa will ensure that CCBHCs are accessible in both urban and rural areas.

B-4. Iowa HHS intends to certify a CCBHC for each of the nine catchment areas during the planning grant period so that we have a comprehensive statewide implementation that offers improved quality and access to all 3.2 million Iowans. We will, however, only do so if there is a provider in each catchment area that is prepared to comply with all 115 CCBHC standards. While we would prefer to have each catchment area covered prior to the demonstration launch, we would rather have a catchment area without one than a catchment area with a CCBHC that cannot comply with the standards. We recognize that it is possible we will enter the demonstration period with catchment areas that lack a CCBHC.



Preliminary Proposed CCBHC Catchments

If that is the case, Iowa HHS intends to implement a rolling application for any catchment area that does not have a state certified CCBHC. We will utilize a version of the application we used for the initial procurement, adapted based on any changes SAMHSA has made to the CCBHC model, and to reflect what Iowa HHS learned during the initial procurement process. Should a provider demonstrate through this application that they can meet all 115 CCBHC standards in a catchment area that lacks a CCBHC, HHS will conduct a desk audit to review all CCBHC

materials, including existing licenses and accreditations, policies and procedures manuals, and staff credentials. Upon successful completion of the desk audit process, providers will be preliminarily certified for an initial 270 days. This is consistent with the methodology Iowa HHS utilizes with our provider licensure and accreditation processes, so it is a process and set of timelines for which our provider community are prepared.

During the 270-day preliminary certification period, Iowa HHS will conduct an on-site audit. This will enable us to review electronic records, case notes, human resources files, signage, and other physical plant aspects. This on-site audit will result in a one-, two-, or three-year certification. If a provider's score qualifies them for a one-year certification they must develop a Corrective Action Plan (CAP) to address documented deficiencies. That plan must be approved by Iowa HHS and in some circumstances triggers another on-site audit. This too is consistent with how Iowa HHS accredits and licenses BH providers in the state.

Similarly, during the demonstration period, if Iowa HHS should find a CCBHC has fallen out of compliance with the CCBHC standards (either through the routine program monitoring process or through the expiration of a CCBHC certification), Iowa HHS will have the right to rescind the CCBHC certification from a provider for a catchment area. Should that occur, Iowa HHS will implement the same rolling application process detailed above.

B-5. Iowa HHS is aware that the planning grant period is short and will require intensive work by members of the administration and the provider community. Due to the tight timelines, during the planning grant period Iowa HHS intends to operate on four parallel tracks to transition from planning for the CCBHC initiative to implementing CCBHCs: Stakeholder input; policy, program development, and procurement; provider training and technical assistance; and PPS development. To drive these processes during the planning grant period, Iowa HHS has budgeted for a Project Director and three Project Coordinators, as well as additional time for the planning team.

Stakeholder input: To prepare this planning grant application, Iowa HHS has solicited stakeholder input from a wide range of people with lived experience of the BH system and their families, Mental Health Planning Council, MHDS Commission, providers, MHDS regions, MCOs, and other stakeholders. This input has been provided to the Iowa HHS CCBHC Workgroup, a workgroup of Iowa HHS leaders from the BH and Disability Services Division and the Medicaid Division. The Iowa HHS CCBHC Workgroup is led by Marissa Eyanson, the BH and Disability Services State Director and is administered by Laura Larkin, Executive Officer. This workgroup was already actively engaged, so when the NOFO for this opportunity was published by SAMHSA, we were prepared to move quickly. The workgroup meets weekly and held a two-day planning retreat following the publication of the NOFO to develop this response and build a blueprint for the planning grant period.

Iowa HHS appreciates that the success of the CCBHC initiative is likely to correlate with the engagement, buy-in, input, and support of our most critical stakeholders, the people we serve, their families, our provider community, and our sister agencies. That is why we have already secured significant stakeholder input through the Iowa Mental Health Planning Council, our MHDS Regional CEO Round Table, meetings with other leaders from Iowa HHS, and existing CCBHC expansion grantees. To ensure that our planning and eventual implementation are informed and supported by a broad foundation of stakeholders, we will empanel a CCBHC Stakeholder Steering Committee to meet at least monthly for the purposes of informing the initiative. In addition to representatives of Iowa HHS, we will include people with lived experience, family members,

provider associations, behavioral health and crisis service providers, MHDS regional representatives, tribal organizations, and representatives of county and municipal governments.

In addition to the monthly meetings with the Interagency CCBHC Workgroup, the Stakeholder Steering Committee will be tasked with holding a series of regional community forums for interested stakeholders in every catchment area so that all Iowans, especially those with lived experience, and those who are from historically underserved communities, will have an opportunity to make their voices, needs, desires, and expectations clear and influence the policy and program development that will be done by the Interagency CCBHC Workgroup.

If Iowa is selected to participate in the demonstration, the Stakeholder Steering Committee will remain empaneled to offer direction, guidance, and support to Demonstration implementation.

Policy, program development, and procurement: Upon receipt of a planning grant award, Iowa HHS will invite representatives of other bureaus and divisions within Iowa HHS and our sister state agencies to join the Iowa HHS CCBHC Workgroup, and in so doing evolve it into an Interagency CCBHC Workgroup. We will extend invitations to Directors (or their delegates) of state agencies who are natural stakeholders for CCBHCs including the Department of Corrections, Department on Aging (which will be joining Iowa HHS on 7/1/23), Commission of Veteran's Affairs, Iowa HHS Bureau of Refugee Services, Department of Human Rights, Department of Education, Department for the Blind, Department of Homeland Security and Emergency Management, Department of Public Safety, Office of Drug Control Policy, and Department of Workforce Development. In this way, we will have access to the insights and priorities of each of the state agencies that will be impacted by (and will impact) the CCBHC initiative.

One of the key deliverables for the Interagency CCBHC Workgroup will be a comprehensive data plan with 3–5-year goals and targeted outcomes for planned improvement. Iowa HHS intends to develop a data plan that will enable us to report not just on outputs of the CCBHC initiative (i.e., how many visits, how many clients), but also outcomes (i.e., reductions in emergency department visits, reductions in inpatient spending, reductions in correctional/law enforcement involvement). We propose to leverage the Iowa BH Reporting System (IBHRS), but there will be many decisions to make about what data to collect, how to define data elements, how to streamline and automate data reporting, what dashboards to develop and how to distribute them, and how data will be aggregated and analyzed. Planning grant funds have been earmarked for the anticipated necessary improvements to IBHRS and to support providers' EHR connectivity.

The Interagency CCBHC Workgroup will also be tasked with completing the CCBHC model design work and developing the numerous documents that will be necessary to transition from planning to implementation. We know we will need many documents to operationalize CCBHCs in Iowa, including certification standards, procurement documents, audit tools, MCO contract amendments, technical guidance for the cost reports, selection criteria, and many other templates, guides, provider materials, and public education documents.

Likewise, because Iowa HHS intends to include CCBHC services within managed care, the Workgroup will ensure adequate representation from multiple disciplines within the State's Medicaid team. Iowa HHS will collaborate with the Medicaid MCOs in Iowa to develop a CCBHC reimbursement policy, contractual requirements, utilization review, monitoring and oversight, network adequacy standards, and outcome and reporting expectations for these critical vendors. Iowa HHS will ensure that managed care capitation rates are adjusted in an actuarially sound manner to both forecast and account for changes in services and utilization associated with the CCBHC initiative.

Iowa HHS's timeline for developing these materials will be driven by the planning grant period, and the desire to ensure meaningful stakeholder engagement, input, and impact. The timeline will enable us to procure CCBHCs for each catchment area in the third quarter of the planning grant year and certify up to nine CCBHCs in the fourth quarter with sufficient time to complete a demonstration grant application by the end of the planning grant year.

The Interagency CCBHC Workgroup, like the CCBHC Stakeholder Steering Committee, will continue to meet regularly during the demonstration grant period should Iowa be selected to participate in the CCBHC demonstration

Provider training and technical assistance: Iowa is fortunate to have a solid base of CCBHC expansion grantees who have leveraged SAMHSA funds to build programmatic and administrative capacity to meet CCBHC standards. Nonetheless, we anticipate that providers throughout the state (those who intend to become CCBHCs and those who will participate by becoming DCOs) will need training, technical assistance, and other support to come into compliance with all 115 CCBHC standards.

Iowa HHS will collaborate with the provider trade associations (including the Iowa BH Association, Iowa Hospital Association BH Affiliate, Iowa Primary Care Association, Iowa Association of Community Providers, and Coalition for Children and Family Services) to facilitate the establishment of learning collaboratives for providers with different levels of readiness, different interest in the initiative, and different community demographics. These learning collaboratives will cover topics like redesigning workflows to meet access standards, managing DCO relationships, PPS cost reporting and calculation, identifying and eliminating health disparities, measurement-based treatment, primary care screening and monitoring, military cultural competence, implementing and monitoring fidelity to evidence-based practices, data collection and sharing, enhancing consumer voice in agency governance, and other topics. Iowa HHS has earmarked a portion of the planning grant funding to secure expert training and technical assistance for our provider community. Iowa HHS intends to continue providing training and technical assistance to CCBHC and DCO providers during the transition to the demonstration period and throughout the four years of the demonstration if we are selected to participate.

PPS development: Iowa HHS understands that even for those providers who received CCBHC Expansion grants, the PPS process will be new. Fortunately, Iowa HHS's Medicaid Division has experience calculating, paying, rebasing, and monitoring PPS payments, experience Iowa HHS intends to leverage in the establishment of a PPS process for CCBHCs that leverages lessons learned from the process currently in place for FQHCs. In addition, Iowa HHS intends to utilize existing CCBHC cost reporting tools developed by SAMHSA and CMS for the demonstration program, including the CMS 10398-43 cost reporting template and the associated cost report instructions. We anticipate supplementing these established tools with additional, Iowa-specific PPS guidance. We understand the SAMHSA/CMS tools may be updated during the planning grant period and are prepared to adapt to any changes proposed by CMS.

Iowa HHS will be supported in the PPS development process by our Medicaid actuarial contractor. To support the transition of PPS payments from planning to implementation, funds from the planning grant have been allocated to support the development of PPS rates for CCBHCs. If Iowa is selected to participate in the demonstration, increased funding for ongoing work related to PPS rate setting is anticipated to continue.

By developing the CCBHC Stakeholder Steering Committee and the Interagency CCBHC Workgroup, Iowa HHS will secure the necessary input within both the community and the

government to move successfully from planning the CCBHC initiative to operationalizing it. By working on four parallel tracks (all benefitting from the input and guidance of the Steering Committee and Workgroup), we will be able to achieve the timelines of the planning grant, procuring CCBHCs in the third quarter of the grant year, and certifying them in the fourth quarter of the grant year before completing a demonstration program application at the conclusion of the planning grant year which will provide the necessary support to enable Iowa HHS to oversee a statewide network of CCBHCs during the four year demonstration.

B-6. Pending further guidance from SAMHSA during the planning grant period, Iowa HHS intends to implement PPS-1 with a Quality Bonus Payment. We have selected PPS-1 because:

Reason	Detail
Better consumer choice	PPS-1 does not require consumers to consolidate their care at one CCBHC for an extended period. Consumers can choose care from multiple CCBHCs or to consolidate with one.
Easier for providers	The cost reporting process is simpler and does not place as much administrative burden on providers as they do not need to calculate their costs by population of service.
More familiar for Iowa HHS	It is consistent with the way Medicaid currently pays a PPS rate to FQHCs. This will make it easier to operationalize and offers Iowa HHS a well-established process to manage rate growth.
Easier for Iowa HHS to implement	Outlier payments do not need to be calculated and paid. Attribution does not need to be tracked. Easier for MMIS to track the data.
Better provider cash flow	Providers can bill daily, which means the length of their revenue cycle (the time between service and payment) will be shorter, which minimizes cash flow problems for providers.
Better data	PPS-1's daily reimbursement leads to more comprehensive and timely data, reducing the claims data lag.
Easier for Medicaid MCOs	Medicaid MCOs are accustomed to paying FQHCs their provider-specific threshold rates, so PPS-1's alignment with FQHC payments ease their policy and technology changes.

Iowa HHS intends to trend provider-specific rates using the Medicare Economic Index (MEI) because it offers a simpler, more predictable, less labor-intensive process for trending provider rates to keep pace with inflation. This is how we trend FQHCs rates, so policies and procedures for doing so are already in place in the Medicaid Division and staff are already trained in how to do so.

We have chosen to implement a QBP because we aim to utilize the CCBHC initiative to improve the quality of BH care available to Iowans as much as possible. We believe that by enabling providers to earn a quality bonus payment of up to 10% of their rate, we will focus staff at all levels of the provider organization on the data that demonstrate high quality outcomes. This is a critical cultural change that we aim to support with the CCBHC payment model. We also intend to use the QBP to spur efforts to address both reporting gaps and inequitable outcomes related to ethnicity, race, age, gender, military service, sexual orientation, and gender identity.

To ensure that CCBHCs are able to provide the necessary supporting data on which to base costs and therefore PPS rates, we will leverage the cost reporting tools developed by SAMHSA and CMS for the demonstration program, including the CMS 10398-43 cost reporting template and associated instructions. We will supplement these documents with Iowa-specific PPS guidance for providers. We understand that those documents may be updated during the planning grant period and are prepared to adapt to any changes proposed by CMS. Providers' capabilities to provide accurate and detailed cost reports will be an important consideration when selecting CCBHCs, but even so, we recognize that providers are likely to need both up front and ongoing support with the

cost reporting process. Iowa HHS will partner one-on-one with each selected CCBHC to make sure the cost reports are completed consistently and on time. To ensure Iowa HHS has the capacity to appropriately and adequately review the supporting documentation offered by providers, the planning grant will provide support to the Iowa Medicaid Division in the development of PPS rates as well as for increased support from the Medicaid actuary.

B-7. Iowa HHS will establish a PPS-1 for CCBHCs in Iowa in accordance with all CMS PPS guidance. Iowa's PPS-1 will be a daily rate that is a flat amount for all CCBHC services provided on any given day to a Medicaid beneficiary. During the planning grant year, Iowa HHS will collect cost and visit data to create the rate for Demonstration Year (DY) 1. The DY1 rate will be updated for DY2 by the MEI. The PPS-1 rate will be calculated based on total annual allowable CCBHC costs divided by the total annual number of CCBHC daily visits, resulting in a uniform payment amount per day, regardless of the intensity of services or individual needs of clinic users on that day. Iowa will include estimated costs related to services or items not incurred during the planning phase but projected to be incurred during the demonstration. During the planning grant year, we will, with input from the Steering Committee, develop policies for rebasing provider PPS rates that are inconsistent with the provider's costs upon retrospective review.

Iowa HHS will include in PPS-1 the cost of Designated Collaborating Organizations (DCOs) engaged in a formal relationship with the CCBHC and delivering services under the same requirements as the CCBHC. Payment for DCO services will be included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS.

Iowa HHS will offer a QBP to CCBHCs that meet performance goals for the six required CCBHC measures: Follow-Up After Hospitalization for Mental Illness (adult age groups), Follow-Up After Hospitalization for Mental Illness (child/adolescents), Adherence to Antipsychotics for Individuals with Schizophrenia, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Adult Major Depressive Disorder (MDD): Suicide Risk Assessment, and Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment. Iowa HHS will set performance goals for these six measures that hold providers to a standard for the whole of their client population, as well as for their performance with historically underserved and marginalized populations, including our populations of focus. This will enable Iowa HHS to appropriately incent providers to make specific outreach to populations of focus and develop programming specific for the unique character of their communities.

With support from the Interagency CCBHC Workgroup, Iowa HHS will establish specific policies for making PPS-1 payments to CCBHCs that are FQHCs, tribal facilities, or providers of clinic services that fall outside of the CCBHC PPS rate. Iowa HHS will adhere to SAMHSA's guidance in establishing these policies.

To determine PPS rates, Iowa HHS will identify allowable costs necessary to support service provision. Iowa HHS will use CMS 10398-43 template and the associated cost report instructions on a demonstration-wide basis. In reporting cost, Iowa HHS will require providers to adhere to 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 14 and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

Iowa HHS will design and implement billing procedures to support the collection of data necessary to help determine program costs and evaluate the overall CCBHC Demonstration. In addition to the data we (in collaboration with MCOs) will collect through the claiming process, we will hold providers accountable for preparing CCBHC cost reports with supporting data so that they can be submitted to CMS no later than 9 months after the end of each CCBHC Demonstration year.

In compliance with 45 CFR §75.302(a), Iowa HHS will have proper fiscal controls in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have been used in compliance with applicable statutes. Additionally, the cost report package and source documentation (e.g., invoices, medical records, cancelled checks) will adhere to federal and state record retention requirements including 45 CFR §75.361 Retention Requirements for Records, and 42 CFR §433.32 Fiscal Policies and Accountability for the Federal Requirements. To demonstrate how costs will be assigned to the different cost centers, Iowa HHS will provide a trial balance reconciled to the cost centers on the cost report. Iowa HHS will adhere to SAMHSA's guidance regarding uncompensated care, telehealth, interpretation and translation, and visit definitions.

Iowa HHS intends to reconcile payments from MCOs to providers with a wraparound payment to ensure actuarial equivalence of PPS rates. Iowa HHS will reconcile managed care payments to CCBHCs with the full PPS rates for covered services to determine whether the minimum payment was achieved. If the minimum payment was not achieved, Iowa HHS will make payments to CCBHCs to make up the shortfall. Iowa HHS proposes to make a CCBHC wraparound payment every three months with an annual reconciliation. In doing so we will consider any CCBHC demonstration services that are already included in managed care capitation rates to avoid duplication of payment. This will enable Iowa HHS to develop actuarially sound rates for payments made through Iowa Medicaid's managed care system.

B-8. See B-1.

B-9. HHS believes strongly in equity and in the impact and value of meaningful governance and representation for individuals served by the CCBHC, individuals with lived experience, and family members. We understand that when representatives share salient characteristics (like race, ethnicity, status as an organization's patient) with those whom they represent, they are more equipped to and effective in advocating for the interests of the people they represent.[55] As such, Iowa HHS strongly supports the CCBHC organizational authority standards, including having a governing Board whose members represent those served in terms of "geographic areas, race, ethnicity, sex, gender identity, disability, age, and sexual orientation."

While we understand that it is difficult for providers to quickly make major changes to the makeup of their Boards of Directors, we expect providers to embrace the imperative and empower the people they serve to exercise governance authority. With input from the Stakeholder Steering Committee and the Interagency CCBHC Workgroup, Iowa HHS intends to develop a timetable for 50%+1 representation of individuals with lived experience and their families on CCBHC Boards by the end of the demonstration period. The initial selection of CCBHCs will prioritize those organizations who already have significant representation on their governing body of individuals served by the CCBHC, people in recovery, and family members.

We recognize that providers will require training and technical assistance to ensure adequate representation of lived experience on their Boards and maximize the value of the voices of those with lived experiences once they are engaged as Board members. The learning collaborative process for providers during the planning grant period will address these changes in governance and will support providers with expert consultation and education about best practices.

B-10. Iowa HHS recognizes that the success of the CCBHC initiative is likely to be driven by the engagement, buy-in, input, and support of our most critical stakeholders, the people we serve, their families, our provider community, and our administration. That is why we have already secured significant stakeholder input through the Iowa Mental Health Planning Council, MHDS Regions, and existing CCBHC expansion grantees.

To ensure that our planning and eventual implementation are informed and supported by as broad a stakeholder group as possible, we intend to empanel a CCBHC Stakeholder Steering Committee to meet at least monthly throughout the planning grant period for the purposes of informing the initiative. In addition to representatives of HHS, we will include people with lived experience, family members, behavioral health and crisis providers, provider associations, regional representatives, tribal organizations, and representatives of county and municipal governments.

In addition to the monthly meetings with the Interagency CCBHC Workgroup, the Stakeholder Steering Committee will be tasked with holding a series of regional community forums for interested stakeholders in every catchment area so that all Iowans, especially those with lived experience, and those who are from historically underserved communities, will have an opportunity to make their voices, needs, desires, and expectations clear and influence the policy and program development that will be done by the Interagency CCBHC Workgroup.

The Steering Committee and the Interagency CCBHC Workgroup will work with the Iowa HHS Office of Health Equity to plan a specific regional forum in Tama County, home to the Meskwaki Nation (Sac and Fox Tribe of the Mississippi in Iowa), Iowa's only federally recognized tribe. In addition, because most of the counties with significant Native American growth in recent years are in central Iowa in and around Polk County (Des Moines), we will ensure that urban American Indians are solicited for input and accounted for in CCBHC planning.

The CCBHC Project Director will establish a website and a listserv for the CCBHC initiative to keep stakeholders informed about meetings, opportunities for input, policy decisions and guidance, training and technical assistance opportunities, and procurements. We will share the web address and the methods for signing up for the listserv at the Medicaid Director's Town Halls, all well as all the public meetings, regional forums, and tribal input sessions held by the Steering Committee. In addition, we will publicize it through Iowa HHS's regular communication channels.

C-1. Since the inception of CCBHCs, Iowa HHS has been committed to developing the model in Iowa. In 2015 we applied to SAMHSA for a CCBHC Planning Grant which enabled Iowa HHS to engage BH providers and stakeholders to initiate planning efforts toward a statewide CCBHC program. Iowa was eager to participate in the Demonstration Program, but we were not selected to participate. Nonetheless, Iowa HHS's commitment and support of the CCBHC program has continued.

Through our 2015 planning efforts Iowa HHS identified several infrastructure and system related issues that inhibited integrated care for the highest need Iowans. When we were not selected for the CCBHC demonstration, we continued to move forward with significant systemwide reform efforts that aligned with the CCBHC program, including bipartisan health reform supporting an enhanced children's mental health system, improved financing for mental health providers, and expanded access to mental health and crisis care. Our regional mental health funding is tied to performance-based contracting which require the provision of core mental health services and approval of budgets. We also have continued to convene stakeholders, including Iowa's CCBHC-E grantees to understand and support their needs through legislative and regulatory changes. Significantly, Iowa has implemented the following initiatives that are consistent with the CCBHC program goals.

Iowa has used Mental Health Block Grant (MHBG) funds to support 12 CMHCs in working towards the CCBHC care model. CMHCs that received MHBG funding had to demonstrate that they improved service delivery for both adults with SMI and children with SED, which included work groups focused on making progress towards compliance with CCBHC criteria, including

training in EBPs. CMHCs implemented system change consistent with the CCBHC Certification Criteria which was tracked quarterly to demonstrate improvement in their respective outcome scores against CCBHC readiness.

Iowa's SABG funded Substance Use and Problem Gambling Services Integrated Provider Network (IPN) were offered additional funding via SAMHSA's COVID-19 Supplement which includes an array or "menu" of options each agency could choose to utilize in an effort to recognize their unique needs. Six (6) agencies, across 8 contracts, chose to engage in TA/T activities to support their pursuit of CCBHC status.

Iowa HHS also holds quarterly meetings with Iowa-based clinics that have received CCBHC Expansion Grants to discuss their progress, needed areas of support, and how to leverage the CCBHC model to improve integrated BH access for Iowans in their service area.

To prepare for this planning grant application, Iowa HHS solicited input from stakeholders in Iowa's BH system. We have convened multidisciplinary leadership and representatives across the system to inform the approach contemplated for the current Planning Grant opportunity. Our stakeholder sessions have focused on understanding the systemic service gaps about which they are most concerned, the populations least well served by the current system. what is working well in Iowa's system and shouldn't be changed, and what data aren't being tracked but should be.

We have used the feedback to inform our strategy in terms of our selected catchment areas for CCBHCs, populations of focus, partnership expectations for DCOs, expanded service requirements, and data collection and quality improvement strategies. As we developed this application, Iowa HHS has met with the following stakeholder groups to inform our planning efforts:

Date	Stakeholder Group
October 20, 2022	Mental Health and Disability Services (MHDS) Commission Meeting
October 20, 2022	Iowa Mental Health Planning Council
November 4, 2022	MHDS Regional CEO Meeting
November 15, 2022	Quarterly Iowa CCBHC Expansion Grantee Meeting
November 28, 2022	IPN Director's Meeting

Additionally, the Iowa CCBHC planning team has been meeting on a weekly basis since the release of the NOFO to refine our implementation approach and collaborate on implementation decisions. The team has identified the regulatory, statutory, and operational next steps that Planning Grant funds will support as Iowa prepares for Demonstration participation. We will organize these activities into a workplan which will guide our key activities to achieve all Grant related activities.

C-2.

Organizations Participating	Role and Responsibility	Demonstrated Commitment
Iowa HHS	DHS (the SMHA and SMA), and IDPH (the SSA) have aligned to form Iowa HHS. All three authorities required for execution of the CCBHC planning grant are now housed within Iowa HHS effective July 1, 2022. We have included a letter signed by the Iowa HHS Director, and the Directors of SMHA, SMA, and SSA to demonstrate our commitment and agreement to collaborate for the implementation and execution of the CCBHC Planning Grant and the CCBHC Demonstration Program.	Memorandum of Agreement (MOA)

Iowa Association of Community Providers (IACP)	IACP represents 153 Iowa organizations that serve individuals with disabilities, MH related disorders and brain injuries.	Letter of Commitment
Iowa Behavioral Health Association (IBHA)	IBHA represents 30 nonprofit licensed / accredited organizations that provide prevention and treatment services for MH, SU and gambling disorders.	Letter of Commitment
Iowa Mental Health Planning Council (MHPC)	MHPC is an advisory body to the State Mental Health Authority within Iowa HHS. The activities of the Council are intended to help support the creation and expansion of comprehensive, community-based systems of care for adults with SMI and children with SED in Iowa.	Letter of Commitment
Iowa Mental Health and Disability Services Commission	MHDS is the state policy-making body for the provision of services to persons with mental illness, intellectual disabilities or other developmental disabilities, or brain injury.	Letter of Commitment

C-3. Iowa will identify appropriate staff to support all deliverables of the planning grant through both existing staff in Iowa HHS and contracted staffing support. For all positions, Iowa will hire individuals who are deeply familiar with Iowa and its existing system of care and possess the expertise to implement a program that will support the highest need Iowans with BH conditions. We will identify individuals who demonstrate an understanding of the culture and language of Iowans at large and within our populations of focus.

Role	Level of Effort	Planning Grant Role and Qualifications
CCBHC Project Director	.5	Laura Larkin will serve as Iowa's CCBHC Project Director. Ms. Larkin is an Executive Officer for BHDS in HHS. She has worked in the BHDS division for 15 years and has over 30 years of human services and MH experience. Ms. Larkin provides MH policy analysis, contract management for community-based MH and disability services and is the SMHG planner. As Project Director, Ms. Larkin will be responsible for the oversight and management of Iowa's Planning Grant and will lead the State's planning efforts toward the development of a Demonstration Program Participation application. Ms. Larkin has lived in Iowa for 54 years and has worked in community MH and child welfare since 1988.
CCBHC Project Coordinator-Management Analyst	1.0	Iowa HHS will hire 1 FTE staff member to assist the Project Director and Project Evaluator with CCBHC oversight and implementation including management of contractors, with emphasis on integration of CCBHC outcomes into the state IBHRS data system.
CCBHC Project Coordinators	2.0	Iowa HHS will contract with two full time equivalents (FTEs) as CCBHC Project Coordinators to support the CCBHC Project Director in the completion and management of all grant-related responsibilities. Each Project Coordinator will be expected to have at least two years BH experience, including project management and coordination. Preference will be given to individuals from Iowa who have worked with our POF or have lived experience.
CCBHC Project Evaluator	.05	Pat McGovern will serve as Iowa's CCBHC Project Evaluator. The Evaluator will oversee Iowa's CCBHC data strategy, including data collection and analysis activities; design, implementation, and reporting on CCBHC program evaluations; ensure data integrity, oversee all elements of grant data and evaluation activities. Mr. McGovern currently serves as Iowa's data lead for IBHRS and Lead for the Iowa Youth Survey. Mr. McGovern has worked for HHS for over 9 years and previously served for 11 years as Program Evaluator and Research Analyst for the Iowa Consortium for Substance Abuse Research and Evaluation.
CCBHC Project Evaluation	1.0	Iowa will contract with one FTE to support the collection and reporting of CCBHC performance outcome measures, measurement of progress toward the state goals and objectives as defined in this grant application, and support participation in all aspects of

		the National Evaluation of the program. Iowa plans to retain support through the University of Northern Iowa (UNI), which has deep experience in conducting research and evaluation on behalf of healthcare stakeholders throughout Iowa.
Director, BHDS	.05	Iowa's BHDS State Director Marissa Eyanson will provide leadership and guidance to the state's CCBHC planning team from a behavioral health programming perspective, to ensure Iowa's CCBHC planning activities align with the State's overall behavioral health reform and improvement strategy. Ms. Eyanson has worked with Iowa HHS for over 9 years, most recently as Iowa's State Director of mental health (SMHA) and the State's Director of ID/DD services. Previously she served as Bureau Chief for Long Term Services and Supports Policy. Ms. Eyanson' s prior experience includes work at a Managed Care Organization leading LTSS Case Management and Transitional Services, serving as Director of Iowa Easter Seals where she provided operational oversight of Case Management, Outreach and Intake, and Quality Improvement, and serving as a direct care provider as a Targeted Case Manager, Service Coordinator and Residential Counselor.
Director, Iowa Medicaid	.05	Iowa's Medicaid Director Elizabeth Matney will provide similar leadership and guidance to the state's CCBHC planning team from a budget, rate development, and financial perspective. Ms. Matney will ensure Medicaid staffing resources are made available to develop PPS methodology and guidance to eligible providers completing cost reports to support CCBHC payment models. Ms. Matney previously served as health policy advisor to the Governor of Iowa, where she worked closely with DHS and IDPH. Ms. Matney's prior experience includes serving as Iowa's Medicaid managed care director, Medicaid quality assurance director, and her early experience includes direct care as a Medicaid provider and work at an Iowa women's shelter.
Bureau Chief, BHDS	.05	The BHDS Bureau Chief, Theresa Armstrong, will provide management and oversight of BHDS staff to guide and direct efforts toward the State's CCBHC planning activities.
Bureau Chief, Bureau of Substance Abuse	.05	The Substance Abuse Bureau Chief, DeAnn Decker, will provide management and oversight of the Bureau of Substance Abuse staff to guide and direct efforts toward the State's CCBHC planning activities.
BH and SUD Policy Specialist, Iowa Medicaid	.05	Hannah Olson, BH and SUD Policy Specialist in Iowa Medicaid will provide management and oversight of the Medicaid program's staff to guide and direct efforts toward the State's CCBHC planning activities, including PPS rate development and cost report submissions.
State 988 Coordinator, BHDS	.05	Julie Maas, BHDS, is the state 988 coordinator, and will provide expertise on integration of CCBHC services with the developing 988 and crisis system

In addition, Iowa will leverage its existing Medicaid rate development support contract with the state's contracted actuary to plan for the CCBHC PPS methodology and rate setting.

D-1. ***Ability to Collect & Report Required Data.*** Iowa HHS will collaborate with potential CCBHCs and other state-level partners to ensure consistent, accurate, and timely collection, monitoring, and interpretation of required performance measures. Iowa currently collects many measures similar to those outlined in the RFA, particularly those mandated for receipt of planning grant funds. The CCBHC planning framework will ensure that input from a range of stakeholders, including individuals and their family members, veterans, BIPOC, rural, and local community organizations is obtained and incorporated into data collection and management process.

Data Collection Plan: The IBHRS system will act as the primary information infrastructure for the BH data needed to report measures. Additionally, a technical data governance and support team will be established to prepare state and provider staff for necessary changes to electronic health record (EHR) systems, provider clinical information systems, the Iowa Medicaid Enterprise Encounter Data (IME) system, the Medicaid management information system (MMIS), our Health Information Exchange (HIE) Cync, and other systems. This workgroup will provide ongoing

guidance and support for development and implementation of CCBHC performance measures. Iowa HHS will support providers to enhance connectivity using a dedicated priority task list.

Planning period priority task list
Identification and resolution of data capacity issues across providers, health plans, and state agencies
Support and facilitation of data integration across systems to conduct population health management data analysis
Facilitation of HIE solutions between CCBHC and Cync HIE including strategies to promote collaboration
Developing provider capacity to develop data collection and registries supporting population health management
Strategy development for dashboards and report templates for monitoring CCBHC metrics and CMS reporting
Decision-point for providing ongoing data support, understanding and solutioning data access, and enhancing data analysis and reporting
Creation of logical processes for the incorporation of data flags in IBHRS to identify, track, and monitor members of CCBHC priority populations so that longitudinal and detailed population health analysis can be conducted

The CCBHC Program Evaluator will be responsible for the data collection and performance measurement during the planning process including retention of local records of data collection that will roll up into the uniform data collection tool provided by SAMHSA. Data will be reported quarterly using the Common Data Platform. Data necessary to report on the specific CCBHC performance measures and a detailed data collection plan is provided in the table below:

Metric	Data Collection Approach
The number of organizations or communities implementing mental health/substance use-related training programs as a result of the grant	A curriculum of all EBP trainings will be provided through Iowa HHS using a learning management system (LMS) where all trainings offered, and attendance lists will be captured. The number of trained personnel, training programs offered, EBPs selected for training, and fidelity metrics will be tracked
The number of people newly credentialed/certified to provide mental health/substance use-related practices/activities that are consistent with the goals of the grant	Credentialling, certification status, and continuing education unit updates will be tracked for all providers ensuring licensure information is complete, accurate, and verified for compliance. This information will be maintained through the LMS system which will be used to link training data to CCBHC personnel to calculate trainings by credential/certification
The number of financing policy changes completed as a result of the grant *The number of policy changes completed as a result of the grant*	Iowa HHS will maintain a log of all changes made to Iowa statutes and Iowa HHS's administrative rules and regulations because of the CCBHC planning grant. The log will also maintain a record of financing policy changes
The number of organizational changes made to support improvement of mental health/substance use-related practices/activities that are consistent with the goals of the grant	Iowa HHS will require CCBHCs to keep a log of all policy and organizational changes including personnel, operations, finance, and clinical programming changes using an Iowa HHS-developed template. Additionally, the Evaluation team will conduct focus groups, and review available annual reports to conduct a content analysis categorizing the type of change for each organization.
The number of communities that establish management information/information technology system links across multiple agencies in order to	Data share and exchange with Cync will be tracked for progress, implementation, and go-live for all providers connecting with the HIE. An audit report will be conducted annually at minimum to identify agencies electronically

share service population and service delivery data as a result of the grant	sharing data with other agencies on CCBHC clients across the state, the number of agencies establishing links to Cync, and the percent of CCBHC clients for whom data are shared electronically.
The number and percentage of work group/advisory group/council members who are recipients/family members	CCBHCs will be required to collect demographic data on all work and advisory group members to ensure consumer/family representation. Additionally, the collection of race/ethnicity, gender, and other demographic data will be conducted annually. These data will be compared against the consumer population data to ensure subpopulations are represented.
The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant	The state will utilize a template to index all MOUs, contracts, and other arrangements among CCBHCs and other organizations. Organization type will be tracked to determine the number of organizations and array of care coordination available across settings for the CCBHC

Data Management, Analysis, & Reporting. Iowa HHS has identified data collection and reporting as a critical piece of our strategy to support engagement, access, quality management, and improved outcomes for individuals. In 2021, Iowa HHS implemented IBHRS, which provides a robust statewide secure technology infrastructure to support CCBHC performance measurement and evaluation. IBHRS can integrate with individual CCBHCs' EHRs. The implementation of IBHRS will help CCBHCs implement the data sharing that enables the integration of BH services CCBHCs are responsible for providing. Iowa HHS will establish bidirectional data flows to support CCBHC performance measurement and continuous quality improvement processes supported by data from IME and MMIS. In addition to IBHRS, the State will require CCBHCs to connect to Cync.

Data gathered throughout the planning period and into the demonstration will be aggregated for individual CCBHCs for the state to comply with reporting requirements and facilitate meaningful data analysis supporting Iowa HHS's quality improvement processes. Data will be monitored monthly and evaluated quarterly for reporting to stakeholders. CCBHC specific performance data will be reviewed regularly by the Project Evaluator, Project Director, and Project Coordinators and shared with the Stakeholder Steering Committee, the Interagency Workgroup and other stakeholders for identification of systemic performance issues, trends, and needs for competency improvement.

Additional Measures. In addition to the required performance measures, the state evaluation team will track adherence to the timeline and logic model to keep key stakeholders informed of progress status and tasks that need to be accomplished. The Project Director will review the project task log, responsibility for each task, and associated target completion dates and communicate project status to the Stakeholder Steering Committee, the Interagency Workgroup and team members. Deviations or delays will be reported and logged along with mitigation solutions so that impact and mitigation actions can be tracked to resolution. Another measure that will be tracked is the development, deployment, and functionality of the data flags distinguishing the individual CCBHCs, the individuals served by CCBHCs, and priority population membership if applicable.

D-2. Iowa HHS will support CCBHCs as they design and build performance measurement processes from the IBHRS infrastructure and implement a quality improvement strategy. As part of the planning phase, collaboration with MCOs will be prioritized to maximize access to data through bi-directional data sharing. Monitoring processes will include oversight of the CCBHC

quality improvement and performance measurement program through continuous monitoring reports of service utilization and measure performance using CCBHC submitted Medicaid data.

Iowa HHS will develop a comprehensive performance measurement infrastructure to guide continuous quality improvement. Iowa HHS will support CCBHC data connectivity with a dedicated technical data governance and support team. This team will support capacity solutions through IBHRS and Cync to allow for data sharing between all providers and with the state to report on outcome measures. Technical assistance and education will be offered to understand the rules, benefits, and challenges of data sharing while improving patient care and coordination. Iowa HHS will monitor the extent to which these functionalities are in place and provide technical assistance to CCBHCs to make data-driven decisions, mine data to understand patient populations, and trend data to identify opportunities for improvement.

Iowa HHS will lead the development and deployment of training series and learning collaboratives to provide educational opportunities for CCBHCs including topics like identification and mitigation of barriers to primary care and behavioral health integration, using data for continuous quality improvement, evidence-based practices, quality improvement, patient registries, meaningful measurement, and benchmarking.

Iowa HHS has procured the IBHRS system to collect, abstract, aggregate, analyze, and monitor data both prospectively and retrospectively to aid in data analysis and population health management. Data from IBHRS will be used to analyze and understand risk, adherence, gaps in care, substandard care, over or underutilization patterns, co-occurring conditions, and other factors that may be undermining health care and increasing costs. The Project Evaluator will work with the BHDS, Medicaid, and Cync data teams to understand trends present in the data and ensure CCBHCs have the right people, processes, and technologies to advance from the current state.

D-3. A team approach to developing an effective monitoring plan while ensuring ongoing quality improvement will be used. This serves several purposes, including the inclusion of diverse perspectives to guide the project and the ability to identify areas in need of improvement while engaging the parties responsible for implementing corrective strategies. The team will monitor performance to determine if the corrective strategies are having the desired effect and provide feedback to stakeholders, clinical teams, and advisory councils. The evaluation team will be part of the larger project team and led by the Project Evaluator. Regular meetings will be convened to review performance data, progress, and results to identify trends in need of remediation. Adherence to goals, objectives, and timeline will be assessed through Plan, Do, Study, Act (PDSA) cycles, root cause analysis, and other continuous quality improvement processes to determine status, barriers, and corrective strategies which will be recorded as part of the process evaluation. A report summarizing the progress on performance measures including accomplishments, processes to understand barriers, and the corrective strategies identified with associated process measures and re-measurement timeframes will be developed and shared quarterly and sent to SAMHSA within 15 days of the conclusion of the reporting quarter. These 'dashboard' reports will be disseminated to all individual CCBHCs and stakeholders, include visualizations of process and outcome measure performance and will callout differences among the CCBHCs progress toward certification.

The performance assessment will also include specialized analyses to determine the existence and impact of current health disparities so future performance can be intentionally monitored and compared for identified disparate performance. The evaluation will analyze data for the existence of disparities within the behavioral health population, with an emphasis on the priority population

memberships to understand access to care and unmet need. Additional assessments on the impact of the CCBHC to those encountering the justice system will be included as data are available to determine usability of the CCBHC flagging procedures functionality to begin testing data reporting on defined populations where behavioral health disparities exist.

D-4. The clinics selected will need to have robust EHRs and health information technology (HIT) to support the metric and quality improvement requirements of the program. A challenge will be the need to modify existing information systems to accommodate the collection of new patient-level metrics specified in the grant. These systems will need to be modified to produce real time reports on sentinel events as well as trend and outlier reports for managing the quality improvement program. These changes will rely on the flexibility of the IT infrastructure within selected CCBHCs. In order to provide requested metrics, CCBHCs will need to receive health information from DCOs, care coordination and other providers outside of the clinic setting. This includes services provided related to health, recovery and home and community-based services that may come from a wide range of providers within the CCBHC's network. An integrated information network solution will be needed to obtain all the health information provided. In addition, CCBHCs will need to provide the state with client level files for the calculation of system wide outcomes and for submission to the national evaluation. The technology needed to compute the metrics and submit data and metrics to the state will need to be developed by the CCBHC.

Iowa HHS will provide resources, training, and technical support to CCBHCs to help mitigate these challenges. In addition, HHS will develop processes for bringing Medicaid claims and IBHRS data together to facilitate comprehensive outcome and financial analyses.

Challenges related to Collection and Measurement of Social Determinants, REaL, and other Member Demographics not Widely Collected. CCBHCs are expected to monitor individual recovery processes and assess social determinants related to health and recovery. Additionally, expansion of demographic data collection, including race, ethnicity, and language needs (REaL), sexual orientation, gender identity (SOGI), etc. are not standard processes currently deployed. Standard measures for recovery, demographics, and social determinants of health have generally been the concern of public health or managed care and are generally not integrated into EHRs. However, to achieve improvements in health outcomes valued by the demonstration, determinants of health—like physical activity levels, employment and living conditions will need to be considered. This work is new and still needs to be operationalized in HIT solutions. This presents a challenge for CCBHCs responsible for monitoring the distal outcomes that are determined by these factors. CCBHCs will need to develop HIT solutions to monitor social and behavioral determinants of health for this population and will require support from HHS in order to do so.

Challenges specific to collection of satisfaction and experience information. The satisfaction and experience data collection process is not standardized and is often managed through the payor or provider. A coordinated effort between the CCBHC and Iowa HHS will need to occur to reduce redundancy and survey burden to participants.

D-5. The Project Evaluator will ensure the state is prepared to participate in the national evaluation for the demonstration program. In collaboration with the Project Director, evaluation team, and technical data governance and support team, data systems and processes will be created to meet national evaluation requirements. These processes will incorporate IBHRS data from CCBHCs on patient intake, IME claims and MMIS encounter data, Cync data, and other health data as available.

Iowa HHS has significant experience collecting patient level data and in working with Medicaid claims and encounter data. Iowa HHS is well prepared to collect the data needed to inform the

national evaluation. Claims and encounter data will be tracked through the IME and MMIS system. Patient record data and chart-based/registry data are captured in IBHRS through the Client Dataset and Patient Data Flow process which utilizes a unique source record identifier. HHS will continue to support EHR vendors with IBHRS technical assistance as needed. CCBHCs will report and track encounter, outcome, and quality data through the IBHRS system, including but not limited to recipient characteristics, staffing capacity, access, service utilization, screening, prevention, and treatment, care coordination, social needs, costs, and recipient outcomes.

Iowa HHS collects treatment level data from providers to meet state and federal data (TEDS, etc.) reporting requirements. Iowa HHS uses data to assist in decision making for system/network improvements, provider service delivery (access, engagement, retention, and completion of treatment), and linkages to associated services and support. The IBHRS Provider Submission Guide specifies the data files and file layout requirements for collecting and reporting required data on individuals served by Iowa HHS licensed SUD treatment providers. The guide also includes technical guidance for a provider agency (submitting entity) to understand how to create file submissions to IBHRS, how to submit those files, and the IBHRS validation rules.

Iowa HHS has developed in-house measures specific to inpatient admissions, readmissions, and non-urgent ED utilization. Additionally, performance reports encompassing an array of cost, quality, access, and parity data position Iowa well to report on the 17 required CCBHC measures and the 15 State Required measures for all Medicaid enrollees in CCBHCs with the ability to distinguish the individual CCBHCs and consumers served by CCBHCs including comparison groups. The CCBHCs will be responsive to changes in metric sets as required by CMS, NCQA, or due to changes in national measure sets. The CCBHCs will also report metrics required to determine the QBPs. CCBHCs will utilize existing EHRs and/or modify EHRs to capture the required data elements. Metrics derived from the Medicaid Adult core metrics set and Medicaid Child Core metrics set will be reported from Medicaid claims and encounter data systems.

Currently, Iowa deploys the Iowa Participant Experience Survey (IPES) and used CAHPS data to monitor and understand the patient experience. IPES data is reviewed quarterly and used to provide training and technical assistance to improve or enhance the overall experience for members. The Iowa HHS quality committee analyzes the findings of the CAHPS data to identify needs for performance improvement activities. To further evolve the ability to meaningfully use patient experience data, CCBHCs will be required to implement the MHSIP recipient survey to report patient experience with care on an annual basis. CCBHCs will also implement the MHSIP family survey to report family experience with care on an annual basis.

CCBHCs will annually submit cost reports with supporting data within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS. Iowa will work with the managed care entities to encourage support of requirements for reporting CCBHC data. The following items will be highlighted as part of this collaborative effort: (1) data to be reported; (2) the period during which data must be collected; (3) the method to meet reporting requirements; and (4) the entity responsible for data collection. Iowa will collect data to allow for oversight of managed care contract execution with CCBHCs and to remedy performance issues.

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** BNF.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Applicant/Recipient	Application/Award Number
Iowa Department of Human Services	SM-23-015

Project Title:	Iowa CCBHC Planning Grant

	Start Date	End Date	Budget Year
Budget Period:	03/30/2023	03/29/2024	1

For Multi-Year Funded (MYF) awards only
(not applicable to new applications for funding)
Check the box to select the Incremental Period ☐

COST SHARING AND MATCHING

Matching Required: ☐ YES ☒ NO

A. Personnel

Line Item #	Position	Name	Key Position per the NOFO	Check if Hourly Rate	Calculation: Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)	Personnel Cost	FEDERAL REQUEST
1	CCBHC Project Coordinator - Management Analyst 3	TBD	☐	☐			1	$75,000	100.00%	$75,000	$75,000
									TOTAL	**$75,000**	**$75,000**

Line Item #	Personnel Narrative:						
1	CCBHC Project Coordinator -Management	TBD		Salary $75,000	# of Staff 1	LOE 100.00%	Personnel Cost $75,000
	The CCBHC Project Coordinator/management analyst will assist the Project Director with CCBHC oversight and implementation including management of contractors, with emphasis on integration of CCBHC outcomes into the state IBHRS data system.						

☒ Show In-Kind Personnel Table

In-Kind Personnel

Line Item #	Position	Name	Key Position per the FOA	Check if Hourly Rate	Hourly Rate	Hours	# of Staff	Annual Salary	% Level of Effort (LOE)
1	Project Director	Laura Larkin	☒	☐			1	$98,196	50.00%
2	State Director of Behavioral Health and Disability Services, SMHA and SSA	Marissa Eyanson	☐	☐			1	$140,886	5.00%
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney	☐	☐			1	$168,251	5.00%
4	Bureau Chief	Theresa Armstrong	☐	☐			1	$128,523	5.00%
5	Bureau Chief	DeAnn Decker	☐	☐			1	$113,152	5.00%
6	Medicaid Policy Subject Matter Expert	Hannah Olson	☐	☐			1	$83,096	5.00%

7	CCBHC Evaluator	Pat McGovern	☐	☐			1	$76,585	5.00%
8	State 988 Coordinator	Julie Maas	☐	☐			1	$73,237	5.00%

Line Item #	In-Kind Personnel Narrative:							
1	Project Director	Laura Larkin	Key Personnel	Salary $98,196	# of Staff 1	LOE 50.00%	Personnel Cost $49,098	
	Laura Larkin, Executive Officer 2 will be the CCBHC project director, will coordinate all CCBHC-grant related activities, direct contracted staff, and be the primary state contact with SAMHSA.							
2	State Director of Behavioral Health and	Marissa Eyanson		Salary $140,886	# of Staff 1	LOE 5.00%	Personnel Cost $7,044	
	Marissa Eyanson, State Director, Behavioral Health and Disability Services,is the SMHA and SSA for the state of Iowa. She will provide oversight and direction for the CCBHC Planning Grant.							
3	State Medicaid Director, State Medicaid Authority	Elizabeth Matney		Salary $168,251	# of Staff 1	LOE 5.00%	Personnel Cost $8,413	
	Elizabeth Matney, State Medicaid Director, is the SMA for the state of Iowa. She will provide oversight and direction for the Medicaid-related activities of the CCBHC Planning Grant.							
4	Bureau Chief	Theresa Armstrong		Salary $128,523	# of Staff 1	LOE 5.00%	Personnel Cost $6,426	
	Theresa Armstrong, Bureau Chief, Behavioral Health and Disability Services, Performance, Innovation, and Mental Health, directly supervises the Project Director and will provide oversight and direction of the CCBHC Planning Grant.							
5	Bureau Chief	DeAnn Decker		Salary $113,152	# of Staff 1	LOE 5.00%	Personnel Cost $5,658	
	DeAnn Decker, Bureau Chief for Behavioral Health and Disability Services, Substance Use Disorder Prevention, Treatment and Recovery will provide oversight and direction regarding substance-use disorder programs, services, and supports.							
6	Medicaid Policy Subject Matter Expert	Hannah Olson		Salary $83,096	# of Staff 1	LOE 5.00%	Personnel Cost $4,155	
	Hannah Olson, Iowa Medicaid Behavioral Health Policy Analyst, is a subject matter expert for Medicaid-funded behavioral health and will provide expertise on Medicaid policy and programs.							
7	CCBHC Evaluator	Pat McGovern		Salary $76,585	# of Staff 1	LOE 5.00%	Personnel Cost $3,829	
	Pat McGovern, Behavioral Health and Disability Services, Substance Use Disorder Prevention, Treatment and Recovery, will serve as the Program Evaluator and assist with oversight of the CCBHC Planning Grant Evaluation and modifications to the state IBHRS system to include mental health data indicators for CCBHC providers.							
8	State 988 Coordinator	Julie Maas		Salary $73,237	# of Staff 1	LOE 5.00%	Personnel Cost $3,662	
	Julie Maas, State 988 Coordinator, will provide direction on integration of the state's CCBHC planning efforts with the state's 988 implementation work.							

B. Fringe Benefits

Our organization's fringe benefits consist of the components shown below:

Fringe Component	Rate (%)
State of Iowa Fringe Benefits-(FICA, IPERS, Health, Dental and Life Insurance, Deferred Compensation and Disability Insurance	32.26%
Total Fringe Rate	32.26%

Fringe Benefits Cost

Line Item #	Position	Name	Calculation				FEDERAL REQUEST
			Personnel Cost	Total Fringe Rate (%)	Fixed / Lump Sum Fringe (if any)	**Fringe Benefits Cost**	
1	CCBHC Project Coordinator -Management Analyst 3	TBD	$75,000	32.26%		$24,195	$24,195
					TOTAL	**$24,195**	**$24,195**

Fringe Benefits Narrative:
State of Iowa Fringe Benefits-(FICA, IPERS, Health, Dental and Life Insurance, Deferred Compensation and Disability Insurance

C. Travel

Trip #	Purpose	Destination	Calculation: Item	Cost / Rate per Item	Basis	Quantity per Person	Number of Persons	Travel Cost	FEDERAL REQUEST
1	CCBHC site visits and other local travel for state staff to attend stakeholder meetings/ engagement	approximately 9 CCBHC sites across Iowa-locations to be determined	Local Travel (POV Mileage)	$0.50	Mile	3,000.00	3	$4,500	$4,500
							TOTAL	$4,500	**$4,500**

Trip #	Travel Narrative:		
1	CCBHC site visits and other local travel for state staff to attend stakeholder meetings/engagement	approximately 9 CCBHC sites across Iowa-locations to be determined	Travel Cost $4,500
	As part of the certification process, the CCBHC project director and other state staff will participate in site visits to each identified CCBHC and participate in stakeholder engagement activities.		

D. Equipment

Line Item #	Item	Check if Item is a Vehicle	Calculation: Quantity	Purchase or Rental/Lease Cost	Percent Charged to the Project	Equipment Cost	FEDERAL REQUEST
1		☐				$0	$0
					TOTAL	**$0**	**$0**

Line Item #	Equipment Narrative:					
1		Quantity	Purchase or Rental/Lease Cost	% Charged to the Project	Equipment Cost	$0
	N/A					

E. Supplies

Line Item #	Item	Calculation: Unit Cost	Basis	Quantity	Duration	Supplies Cost	FEDERAL REQUEST
1	Laptop computers, docking stations, and software package	$1,450.00		3.00		$4,350	$4,350
2	Cell phone services $40 per month	$40.00		3.00	12.00	$1,440	$1,440
3	Cell phone purchase-one time cost	$50.00		3.00		$150	$150
4	Printing	$0.20		5,000.00		$1,000	$1,000
5	General office supplies	$25.00		3.00	12.00	$900	$900

Line Item #	Item	Calculation					FEDERAL REQUEST
		Unit Cost	Basis	Quantity	Duration	Supplies Cost	
					TOTAL	$7,840	$7,840

Line Item #	Supplies Narrative:					
1	Laptop computers, docking stations, and software pac	Unit Cost $1,450.00	Basis	Quantity 3.00	Duration	Supplies Cost $4,350
	Laptops for 3 project coordinators for work on the CCBHC planning grant.					
2	Cell phone services $40 per month	Unit Cost $40.00	Basis	Quantity 3.00	Duration 12.00	Supplies Cost $1,440
	Cell phone service for 3 project coordinators for work on the CCBHC planning grant					
3	Cell phone purchase-one time cost	Unit Cost $50.00	Basis	Quantity 3.00	Duration	Supplies Cost $150
	Purchase of 3 cell phones for project coordinators for work on the CCBHC planning grant					
4	Printing	Unit Cost $0.20	Basis	Quantity 5,000.00	Duration	Supplies Cost $1,000
	Printing for stakeholder engagement events and presentations.					
5	General office supplies	Unit Cost $25.00	Basis	Quantity 3.00	Duration 12.00	Supplies Cost $900
	Miscellaneous office supplies for project coordinators					

F. Contractual

Summary of Contractual Costs

Agree-ment #	Name of Organization or Consultant	Type of Agreement	Contractual Cost	FEDERAL REQUEST
1	University of Iowa-Center for Disabilities and Development	Subaward	$176,000	**$176,000**
2	Project Evaluation Entity-TBD	Subaward	$160,000	**$160,000**
3	Contracts with CCBHC grantees	Subaward	$180,000	**$180,000**
4	PPS Rate Development	Subaward	$100,000	**$100,000**
5	State Data System Enhancements/IBHRS	Subaward	$180,000	**$180,000**
6	Learning Collaboratives for CCBHCs-TBD	Subaward	$92,465	**$92,465**
	TOTAL		**$888,465**	**$888,465**

Contractual Details for **University of Iowa-Center for Disabilities and Development**

Agree-ment #	Services and Deliverables Provided
1	Services of 2 FTE Program Coordinators to assist state staff in management and coordination of all required grant activities including CCBHC certification processes, PPS development, learning collaboratives, and stakeholder engagement with behavioral health providers, stakeholders, individuals and family members of individuals with lived experience.

☒ Personnel ☒ Travel ☐ Supplies ☐ Indirect Charges

☐ Fringe Benefits ☐ Equipment ☐ Other

Contractual Personnel Costs for University of Iowa-Center for Disabilities and Development

Line Item #	Position	Name	Key Position per the NOFO	Check if Annual Salary	Calculation						FEDERAL REQUEST
					Hourly Rate	Hours	# of Persons	Annual Salary	% Level of Effort (LOE)	**Contractual Personnel Cost**	
1	Program Coordinator 1	TBD	☐	☒			1	$85,000	100.00%	$85,000	$85,000
2	Program Coordinator 2	TBD	☐	☒			1	$85,000	100.00%	$85,000	$85,000
									TOTAL	**$170,000**	**$170,000**

Line Item #	Contractual Personnel Narrative:						
1	Program Coordinator 1	TBD		Salary $85,000	# of Persons 1	LOE 100.00%	Personnel Cost $85,000
	Program Coordinator 1 will assist state staff in management and coordination of all required grant activities including CCBHC certification processes and stakeholder engagement with behavioral health providers, stakeholders, consumers, and family members of consumers of behavioral health services. This position will also assist with coordination of the Medicaid PPS rate development process.						
2	Program Coordinator 2	TBD		Salary $85,000	# of Persons 1	LOE 100.00%	Personnel Cost $85,000
	Program Coordinator 2 will assist state staff in management and coordination of all required grant activities including CCBHC certification processes and stakeholder engagement with behavioral health providers, stakeholders, consumers, and family members of consumers of behavioral health services.						

Contractual Travel Costs for University of Iowa-Center for Disabilities and Development

Trip #	Purpose	Destination	Calculation						FEDERAL REQUEST
			Item	Cost / Rate per Item	Basis	Quantity per Person	Number of Persons	**Contract Travel Cost**	
1	CCBHC site visits and other local travel for stakeholder meetings/ engagement	approximately 9 sites across Iowa-location to be determined	Local Travel (POV Mileage)	$0.50	Mile	6,000.00	2	$6,000	$6,000
							TOTAL	$6,000	**$6,000**

Trip #	Contractual Travel Narrative:			
1	CCBHC site visits and other local travel for stakeholder meetings/ engagement	approximately 9 sites across Iowa-location to be determined	Travel Cost	$6,000
	Mileage for contracted staff to conduct site visits to CCBHC sites.			

Contractual Total Direct Charges for University of Iowa-Center for Disabilities and Development

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$176,000

Contractual Total Cost for University of Iowa-Center for Disabilities and Development

TOTAL COST	TOTAL FEDERAL REQUEST
$176,000	$176,000

Contractual Details for Project Evaluation Entity-TBD

Agree-ment #	Services and Deliverables Provided
2	Provide required evaluation services for planning grant activities and provide assistance to the state in development of evaluation and data analysis for the Demonstration Grant application

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Project Evaluation Entity-TBD

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Evaluation services	☐	$160,000.00		1.00		**$160,000**	$160,000
						TOTAL	**$160,000**	**$160,000**

Line Item #	Contractual Other Narrative:					
	Evaluation services	Unit Cost/Rate $160,000.00	Basis	Quantity 1.00	Duration	Other Cost $160,000
1	The state intends to contract with an external evaluator with expertise in research and evaluation of federal grants. The contracted evaluation entity will be responsible for collection and reporting of CCBHC performance outcome measures, measurement of progress toward the state goals and objectives as defined in this grant application, and support participation in all aspects of the National Evaluation of the program.					

Contractual Total Direct Charges for Project Evaluation Entity-TBD

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$160,000

Contractual Total Cost for Project Evaluation Entity-TBD

TOTAL COST	TOTAL FEDERAL REQUEST
$160,000	$160,000

Contractual Details for Contracts with CCBHC grantees

Agree-ment #	Services and Deliverables Provided
3	Contracts for 9 CCBHC grantees selected through a competitive process

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Contracts with CCBHC grantees

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Funds to CCBHC selected through competitve process to support completion of certification requirements	☐	$20,000.00		9.00		**$180,000**	$180,000
						TOTAL	**$180,000**	**$180,000**

Line Item #	Contractual Other Narrative:					
1	Funds to CCBHC selected through competitve pro	Unit Cost/Rate $20,000.00	Basis	Quantity 9.00	Duration	Other Cost $180,000
	Iowa plans to contract with 9 community behavioral health organizations who will work toward certification as CCBHCs. Funds will be used by organizations to address EHR enhancements, PPS development, and other activities required to meet CCBHC certification criteria.					

Contractual Total Direct Charges for Contracts with CCBHC grantees

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$180,000

Contractual Total Cost for Contracts with CCBHC grantees

TOTAL COST	TOTAL FEDERAL REQUEST
$180,000	$180,000

Contractual Details for PPS Rate Development

Agree-ment #	Services and Deliverables Provided
4	Develop the state's PPS and quality bonus payment methodology

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges

☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for PPS Rate Development

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	PPS rate development	☐	$100,000.00		1.00		**$100,000**	$100,000
						TOTAL	**$100,000**	**$100,000**

Line Item #	Contractual Other Narrative:					
1	PPS rate development	Unit Cost/Rate $100,000.00	Basis	Quantity 1.00	Duration	Other Cost $100,000
	The state will contract with Iowa Medicaid's actuarial provider to develop PPS-1 uniform cost reporting and rate development for the CCBHC demonstration program.					

Contractual Total Direct Charges for PPS Rate Development

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$100,000

Contractual Total Cost for PPS Rate Development

TOTAL COST	TOTAL FEDERAL REQUEST
$100,000	$100,000

Contractual Details for State Data System Enhancements/IBHRS

Agree-ment #	Services and Deliverables Provided
5	The state will contract with the vendor for the Iowa Behavioral Health Reporting System (IBHRS) to develop capacity for reporting of CCBHC demonstration program outcomes within the existing state system used for SUD provider reporting.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for State Data System Enhancements/IBHRS

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Expansion of Iowa Behavioral Health Reporting System to include CCBHC outcome datasets	☐	$150,000.00	Estimated costs to add new datasets to existing system	1.00		**$150,000**	$150,000
2	Monthly hosting and maintenance costs	☐	$5,000.00	estimated monthly costs	6.00		**$30,000**	$30,000
						TOTAL	**$180,000**	**$180,000**

Line Item #	Contractual Other Narrative:						
1	Expansion of Iowa Behavioral Health Reporting S	Unit Cost/Rate $150,000.00	Basis Estimated costs to add	Quantity 1.00	Duration	Other Cost $150,000	
	The state will work with the vendor for the IBHRS system to develop capacity for reporting of CCBHC Demonstration grant outcomes.						
2	Monthly hosting and maintenance costs	Unit Cost/Rate $5,000.00	Basis estimated monthly costs	Quantity 6.00	Duration	Other Cost $30,000	
	Costs for monthly support, maintenance and hosting of the IBHRS system						

Contractual Total Direct Charges for State Data System Enhancements/IBHRS

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$180,000

Contractual Total Cost for State Data System Enhancements/IBHRS

TOTAL COST	TOTAL FEDERAL REQUEST
$180,000	$180,000

Contractual Details for Learning Collaboratives for CCBHCs-TBD

Agree-ment #	Services and Deliverables Provided
6	The contractor will develop learning collaboratives for prospective CCBHCs and DCOs to support the programs to make programmatic changes required to meet CCBHC certification criteria. These learning collaboratives will cover topics such as redesigning workflows to meet access standards, managing DCO relationships, PPS cost reporting and calculation, identifying and eliminating health disparities, measurement-based treatment, primary care screening and monitoring, military cultural competence, implementing and monitoring fidelity to evidence-based practices, data collection and sharing, enhancing consumer voice in agency governance, and other topics.

☐ Personnel ☐ Travel ☐ Supplies ☐ Indirect Charges
☐ Fringe Benefits ☐ Equipment ☒ Other

Contractual Other Costs for Learning Collaboratives for CCBHCs-TBD

Line Item #	Item	Check for Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	**Contractual Other Cost**	
1	Learning Collaboratives-training and TA for potential CCBHCs and DCOS	☐	$92,465.00		1.00		**$92,465**	$92,465
						TOTAL	**$92,465**	**$92,465**

Line Item #	Contractual Other Narrative:					
1	Learning Collaboratives-training and TA for poten	Unit Cost/Rate $92,465.00	Basis	Quantity 1.00	Duration	Other Cost $92,465
	Contract for provision of learning collaboratives for prospective CCBHCs and DCOs to support the programs to make programmatic changes required to meet CCBHC certification criteria.					

Contractual Total Direct Charges for Learning Collaboratives for CCBHCs-TBD

TOTAL DIRECT CHARGES FOR THIS AGREEMENT	TOTAL FEDERAL REQUEST
	$92,465

Contractual Total Cost for Learning Collaboratives for CCBHCs-TBD

TOTAL COST	TOTAL FEDERAL REQUEST
$92,465	$92,465

G. Construction: Not Applicable

H. Other

Line Item #	Item	Check if Minor A&R	Calculation					FEDERAL REQUEST
			Unit Cost / Rate	Basis	Quantity	Duration	Other Cost	
1		☐					$0	$0
						TOTAL	$0	$0

Line Item #	Other Narrative:					
1		Unit Cost/Rate	Basis	Quantity	Duration	Other Cost $0

I. Total Direct Charges

TOTAL DIRECT CHARGES	TOTAL FEDERAL REQUEST
	$1,000,000

J. Indirect Charges

Type of IDC Rate / Cost Allocation Plan

We will not charge IDC to the award

Indirect Charges

End Date of Effective Period of Approved IDC Rate Agreement	Calculation			FEDERAL REQUEST
	Approved IDC Rate (%)	Approved Base	IDC	
N/A	0.00%	$0	$0	$0
		TOTAL	$0	$0

Indirect Charges Narrative:

REVIEW OF COST SHARING AND MATCHING

Cost sharing or matching is not required for this grant.

BUDGET SUMMARY: YEAR 1

BUDGET CATEGORY	FEDERAL REQUEST
A. Personnel	$75,000
B. Fringe Benefits	$24,195
C. Travel	$4,500

D. Equipment	$0
E. Supplies	$7,840
F. Contractual	$888,465
G. Construction (N/A)	$0
H. Other	$0
I. Total Direct Charges (sum of A to H)	**$1,000,000**
J. Indirect Charges	$0
Total Projects Costs (sum of I and J)	**$1,000,000**

BUDGET SUMMARY FOR REQUESTED FUTURE YEARS

	Year 2	Year 3	Year 4	Year 5
Budget Category	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**	**FEDERAL REQUEST**
A. Personnel				
B. Fringe Benefits				
C. Travel				
D. Equipment				
E. Supplies				
F. Contractual				
G. Construction	$0	$0	$0	$0
H. Other				
I. Total Direct Charges (sum A to H)	**$0**	**$0**	**$0**	**$0**
J. Indirect Charges				
Total Project Costs (sum of I and J)	**$0**	**$0**	**$0**	**$0**

Budget Summary Narrative:

FUNDING LIMITATIONS / RESTRICTIONS

Funding Limitation/Restriction
No more than 20% of the total award for the budget period may be used for data collection, performance measurement, and performance assessment activities required.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total for Budget Category
A. Personnel						

B. Fringe Benefits						
C. Travel						
D. Equipment						
E. Supplies						
F. Contractual	$160,000					$160,000
H. Other						
I. Total Direct Charges (sum A to H)	**$160,000**					**$160,000**
J. Indirect Charges						
TOTAL for the Budget Year	**$160,000**					**$160,000**
Percentage of the Budget	16.000%					

Funding Limitation/Restriction Narrative:

The state intends to contract with an external evaluator with expertise in research and evaluation of federal grants. The contracted evaluation entity will be responsible for collection and reporting of CCBHC performance outcome measures, measurement of progress toward the state goals and objectives as defined in this grant application, and support participation in all aspects of the National Evaluation of the program. The amount budgeted is 16% of the total budget and under the grant limit.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SM-23-015 CCBHC Planning Grant	93.829			$1,000,000	$0	$1,000,000
2.						
3.						
4.						
5. Totals				$1,000,000	$0	$1,000,000

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) CCBHC Planning Grant	(2)	(3)	(4)	
a. Personnel	$75,000	$0			$75,000
b. Fringe Benefits	$24,195	$0			$24,195
c. Travel	$4,500	$0			$4,500
d. Equipment	$0	$0			$0
e. Supplies	$7,840	$0			$7,840
f. Contractual	$888,465	$0			$888,465
g. Construction	$0	$0	$0	$0	$0
h. Other	$0	$0			$0
i. Total Direct Charges (sum of 6a-6h)	$1,000,000	$0			$1,000,000
j. Indirect Charges	$0	$0			$0
k. TOTALS (sum of 6i and 6j)	$1,000,000	$0			$1,000,000
7. Program Income					

Authorized for Local Reproduction

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. SM-23-015 CCBHC Planning Grant				
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$1,000,000	$250,000	$250,000	$250,000	$250,000
14. Non-Federal					
15. TOTAL (sum of lines 13 and 14)	$1,000,000	$250,000	$250,000	$250,000	$250,000

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. SM-23-015 CCBHC Planning Grant	$0	$0	$0	$0
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$0	$0	$0	$0

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

OMB Number: 4040-0007
Expiration Date: 02/28/2025

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593(identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Completed on submission to Grants.gov	Director, Behavioral Health and Disability
APPLICANT ORGANIZATION	DATE SUBMITTED
Iowa Department of Human Services	Completed on submission to Grants.gov

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Other Attachment File(s)

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STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Kim Reynolds
GOVERNOR

Adam Gregg
LT. GOVERNOR

Kelly Garcia
DIRECTOR

Attachment 1-State Agency Structure

December 12, 2022

Mary Blake
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Email: CCBHC@samhsa.hhs.gov

Dear Ms. Blake:

This letter identifies the roles of the State Mental Health Authority (SMHA), the Single State Agency (SSA), and the State Medicaid Authority (SMA) within the structure of the Iowa Department of Health and Human Services (Iowa HHS) for the state's application for SM-23-015 the CCBHC Planning Grant opportunity.

The Iowa Department of Human Services (DHS), the SMHA and SMA, and the Iowa Department of Public Health (IDPH), the SSA, have aligned to form Iowa HHS. All three authorities required for collaboration for implementation and execution of the CCBHC planning grant are now housed within the Iowa Department of Health and Human Services effective July 1, 2022. Iowa HHS is currently in a transition period toward full integration. DHS, the legacy State Mental Health Authority (SMHA), is the applicant agency for this project as business operations are being transitioned to Iowa HHS. Throughout the application DHS will be referred to as Iowa HHS.

The alignment brings the three state-level authorities together under the leadership of Director Kelly Garcia and includes the SMHA and the SSA within the Division of Behavioral Health and Disability Services (BHDS). The three state-level authorities and their roles are:

Authority	Iowa HHS location	Activities
State Mental Health Authority	Iowa HHS BHDS, previously the DHS Division of Mental Health and Disability Services, (MHDS) administers MH services.	BHDS is the state MH authority (SMHA) in Iowa and is responsible for 14 MHDS regions, accreditation of community mental health centers (CMHCs), mental health service providers (MHSPs), crisis service providers, and certain non-behavioral health service providers. There are 14 MHDS Regions that manage and oversee delivery of required core adult and child services and evidence-based practices. Regions also work with Iowa Medicaid to monitor network adequacy.
Single State Agency	Iowa HHS BHDS, previously the IDPH Division of Behavioral	BHDS is responsible for licensure of all SUD treatment programs, and for administration of state SUD appropriations and the Substance Abuse Prevention and Treatment Block Grant. BHDS manages the

	Health, administers SUD services.	Integrated Provider Network (IPN) to increase access to SUD services. SUD providers must be licensed by Iowa HHS to provide SUD services in Iowa.
State Medicaid Authority	Iowa HHS Medicaid	Medicaid services, including services for MH/SUD, are administered by Iowa Medicaid.

Iowa HHS, representing the SMHA, SSA, and SMA, commits to collaborate for the implementation and execution of the Fiscal Year 2023 Cooperative Agreement for Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and the CCBHC Demonstration Program and to collaborate and certify clinics as CCBHCs, establish a Prospective Payment System, and to submit a proposal to participate in the CCBHC Demonstration program during the planning grant period.

Sincerely,

Kelly Garcia

Kelly Garcia, Director

Elizabeth Matney

Elizabeth Matney, State Medicaid Director

Marissa Eyanson

Marissa Eyanson, State Director, Behavioral Health and Disability Services

Iowa Mental Health Planning and Advisory Council

Chair: Teresa Bomhoff

Vice-Chair: Kyra Hawley

"Serving the Mental Health Needs of Iowans"

Date 12-12-22

Marissa Eyanson, Division Director
Iowa Department of Health and Human Services
Behavioral Health and Disability Services
321 E. 12th St.
Des Moines, IA 50319

The Iowa Mental Health Planning Council is pleased to partner with the Iowa Department of Health and Human Services *(formerly known as the Iowa Department of Human Services and the Iowa Department of Public Health)* for the implementation and execution of the Fiscal Year 2023 Cooperative Agreement for Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and the CCBHC Demonstration Program.

The planning grant proposes to build on current initiatives in Iowa, including regional development of crisis services and the 988 crisis line, the integration of the state departments of human services and public health, and other system change initiatives to implement an enhanced model of community mental health and substance use disorder services through development of Certified Community Behavioral Health Clinics.

As Chairperson, I commit my organization to partner and participate in all relevant planning activities to support Iowa's planning grant and CCBHC Demonstration program.

Sincerely,

Teresa Bomhoff
Chairperson
Iowa Mental Health Planning Council

IACP
Iowa Association of Community Providers

December 12, 2022

Marissa Eyanson, Division Director
Iowa Department of Health and Human Services
Behavioral Health and Disability Services
321 E 12th St.
Des Moines, IA 50319

Dear Ms. Eyanson;

The Iowa Association of Community Providers (IACP) is pleased to partner with the Iowa Department of Health and Human Services (formerly known as the Iowa Department of Human Services and the Iowa Department of Public Health) for the implementation and execution of the Fiscal Year 2023 Cooperative Agreement for Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and the CCBHC Demonstration Program.

The planning grant proposes to build on current initiatives in Iowa, including regional development of crisis services and the 988-crisis line, the integration of the state departments of human services and public health, and other system change initiatives to implement an enhanced model of community mental health and substance use disorder services through development of Certified Community Behavioral Health Clinics.

As Chief Executive Officer, I commit my organization to partner and participate in all relevant planning activities to support low's planning grant and CCBHC Demonstration program.

Sincerely,

Shelly Chandler

Shelly Chandler
Chief Executive Officer
The Iowa Association of Community Providers

iowaproviders.org 7025 Hickman Road, Suite 5 / Urbandale, Iowa 50322 / 515.270.9495

Iowa Behavioral Health Association

2900 100th Street, Suite 200, Urbandale IA 50322
515.309.3315 office
www.ibha.org
Flora@ibha.org

December 14, 2022

Marissa Eyanson, Division Director
Iowa Department of Health and Human Services
Behavioral Health and Disability Services
321 E. 12th St.
Des Moines, IA 50319

The Iowa Behavioral Health Association looks forward to our continued partnership with the Iowa Department of Health and Human Services (formerly known as the Iowa Department of Human Services and the Iowa Department of Public Health) for the implementation and execution of the Fiscal Year 2023 Cooperative Agreement for Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and the CCBHC Demonstration Program.

The planning grant proposes to build on current initiatives in Iowa, including regional development of crisis services and the 988 crisis line, the integration of the state departments of human services and public health, and other system change initiatives to implement an enhanced model of community mental health and substance use disorder services through the development of Certified Community Behavioral Health Clinics.

Iowa has been fortunate to have 14 provider agencies within our state receive CCBHC grant funding over the past several years. Of these provider agencies, 11 are members of IBHA and we hold monthly meetings for these grantee executive directors and staff to share ideas, best practices, successes and challenges, and to discuss the impact the CCBHC model is having upon their respective behavioral health operations and ultimately leading to improved services and better outcomes for individuals across our state.

As Executive Director, I commit the Iowa Behavioral Health Association to partner with and to actively participate in the relevant organizational activities in support of Iowa's Planning Grant and CCBHC Demonstration Program.

Respectfully,

Flora A. Schmidt, Executive Director
Iowa Behavioral Health Association

IBHA is the leading voice to enhance the effectiveness and resiliency of nonprofit licensed/accredited organizations that provide prevention and treatment services for mental health, substance use, and gambling disorders. We represent 29 agencies across Iowa and a listing of member locations as well as programs and services offered is available at: https://www.ibha.org/preferred-providers/

Advocacy & Knowledge Sharing for the Advancement of the Behavioral Health Field

STATE OF IOWA DEPARTMENT OF
Health and Human SERVICES

Kim Reynolds
GOVERNOR

Adam Gregg
LT. GOVERNOR

Kelly Garcia
DIRECTOR

Iowa Mental Health and Disability Services Commission

December 14, 2022

Marissa Eyanson, Division Director
Iowa Department of Health and Human Services
Behavioral Health and Disability Services
321 E. 12th St.
Des Moines, IA 50319

The Mental Health and Disability Services (MHDS) Commission is pleased to partner with the Iowa Department of Health and Human Services (formerly known as the Iowa Department of Human Services and the Iowa Department of Public Health) for the implementation and execution of the Fiscal Year 2023 Cooperative Agreement for Certified Community Behavioral Health Clinic (CCBHC) Planning Grant and the CCBHC Demonstration Program.

The planning grant proposes to build on current initiatives in Iowa, including regional development of crisis services and the 988 crisis line, the integration of the state departments of human services and public health, and other system change initiatives to implement an enhanced model of community mental health and substance use disorder services through development of Certified Community Behavioral Health Clinics.

As Chair, I commit my organization to partner and participate in all relevant planning activities to support Iowa's planning grant and CCBHC Demonstration program.

Sincerely,

Russell Wood
Chair

Data Collection Instruments/Interview Protocols

Links to Iowa Behavioral Health Reporting System (IBHRS) Data Collection Instruments:

https://idph.iowa.gov/Bureau-of-Substance-Abuse/Substance-Use-and-Problem-Gambling-Data/Iowa-Behavioral-Health-Reporting-System/IBHRS-Documentation

Client Data Set- https://idph.iowa.gov/Portals/1/userfiles/284/NL/Paper%20Forms%20-%20Client%20Data%20SetV2.pdf

Service Event Data Form:
https://idph.iowa.gov/Portals/1/userfiles/284/NL/Paper%20Forms%20-%20Service%20Event%20Data%20SetV2.pdf

Treatment Episode Data Entry Form:
https://idph.iowa.gov/Portals/1/userfiles/284/NL/Paper%20Forms%20-%20Treatment%20Episode%20Data%20Set_6_23_32.pdf

Biographical Sketch and Position Descriptions

Key Position: Project Director (.5 FTE)

Biographical Sketch: Laura Larkin will serve as Iowa's CCBHC Project Director. Ms. Larkin is an Executive Officer for the Behavioral Health and Disability Services (BHDS) Division in Iowa HHS. Ms. Larkin obtained a B.A. in Sociology from Central College, Pella IA in 1988 and a M.S in Human Resources in 1994 from East Central University in Ada, OK.

She has worked in the BHDS division for 15 years and has over 30 years of human services and MH experience. Ms. Larkin provides MH policy analysis, contract management for community-based MH and disability services and is the State MHBG planner. As Project Director, Ms. Larkin will be responsible for the oversight and management of Iowa's Planning Grant and will lead the State's planning efforts toward the development of a Demonstration Program Participation application. Ms. Larkin has lived in Iowa for 54 years and has worked in community MH and child welfare since 1988. Ms. Larkin works directly with CMHCs, community providers, and stakeholders through Iowa's MHBG planning work and contract management activities.

Project Director Position Description

Position Description: The Project Director is responsible for managing the CCBHC Planning Grant Project at the strategic level for the Iowa Department of Health and Human Services. The Director will provide overall coordination, implementation, and execution of the CCBHC project under the supervision of Iowa HHS BHDS Bureau Chief of Performance, Innovation and Mental Health. Position will be .5 FTE.

Duties and responsibilities include:

1) Leads the planning and implementation of CCBHC project including developing plans, creating, and enforcing timeline and ensuring the project remains on track.
2) Creates work plan to assign duties, responsibilities, and scope of authority. Facilitate the definition of project scope, goals, and deliverables for the project.
3) Define and track project tasks and resource requirements.
4) Manage project budget and resource allocation.
5) Ensure compliance with all relevant policy and procedures and applicable local, state, and federal regulations.
6) Facilitate and lead effective project team meetings, including CCBHC stakeholder engagement.
7) Oversee quality assurance and ensuring the project is "audit ready" at all times.
8) Production and presentation of key project progress reports to both internal and external meetings and conferences.

Qualifications & Personal Qualities

1) baccalaureate degree in a relevant behavioral health or human services field
2) experience working with the designated population and subpopulations
3) experience staffing interagency groups and/or experience working across state systems to make policy change
4)experience in developing successful grant applications
5)experience organizing training and technical assistance events
6)Flexibility, self-direction, and ability to manage multiple tasks simultaneously

Skills and Knowledge Required: Must have excellent leadership, organizational, verbal communication, writing, and facilitation skills. Knowledge and experience with Iowa's publicly funded behavioral health system is preferred.

Supervisory Relationships

The Project Director will be directly supervised by the Bureau Chief, Bureau of Performance, Innovation, and Mental Health. The Project Director will oversee the Program Coordinators.

Travel

In-state travel is required for stakeholder meetings, training events, and other meetings as needed.

Salary

$63,481-$98,196/annually

Program Coordinator Position Description-Full Time

Program coordinators are responsible for assisting the Project Director with coordination of all activities required through Iowa's CCBHC Planning Grant. This includes assisting with coordination and implementation of CCBHC certification processes, data collection activities, PPS development, learning collaboratives, and stakeholder engagement with behavioral health providers, provider associations, stakeholders, individuals with lived experience, and family members of individuals with lived experience.

Qualifications:

1) Bachelor's degree in a relevant behavioral health or human services field
2) Experience working with the designated population and subpopulations
3) Experience staffing interagency groups and/or experience working across state systems to implement policy change
4) Experience organizing training and technical assistance events
5) Flexibility, self-direction, and ability to manage multiple tasks simultaneously

Skills and Knowledge Required:

Excellent organizational skills, verbal communication, writing, and facilitation skills. Knowledge and experience with Iowa's publicly funded behavioral health system is preferred.

Supervisory Relationships:

Program Coordinators will work under the direction of the CCBHC Program Director.

Travel:

In-state travel will be required for stakeholder meetings and CCBHC site visits.

Salary Range:

$60,000-89,000/annually

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Kim Reynolds
GOVERNOR

Adam Gregg
LT. GOVERNOR

Kelly Garcia
DIRECTOR

Attachment 4 – Statement of Intent

December 19, 2022

If selected to participate in the CCBHC Demonstration program, the state of Iowa agrees to pay for services at the rate established under the prospective payment system during the CCBHC demonstration program. No payments will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, or to satellite facilities of CCBHCs if such facilities were established after April 1, 2014.

Sincerely,

Kelly Garcia

Kelly Garcia, Director

OMB Control Number 0945-0008
Exp. Date: 12/31/2022

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND ANTI-DISCRIMINATION LAWS

*With respect to compliance with 45 C.F.R. Part 88, the signatory is providing assurance of compliance with such Part to the extent it is in effect during the term of the award. Consistent with applicable court orders, the version of Part 88 in effect as of December 2, 2019, is found at 76 Fed. Reg. 9,976-77 (February 23, 2011).

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964, as amended (codified at 42 U.S.C. § 2000d *et seq.*), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972, as amended (codified at 20 U.S.C. § 1681 *et seq.*), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975, as amended (codified at 42 U.S.C. § 6101 *et seq.*), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

6. As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (*e.g.,* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Div. B., sec. 507(d), Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018), as extended by the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, Div. A., sec. 101(8), 133 Stat. 1093, 1094 (Sept. 27, 2019)), Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and other Federal conscience and anti-discrimination laws, including but not limited to those listed at https://www.hhs.gov/conscience/conscience-protections, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 88), to the end that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance or other Federal funds from the Department for which the Federal conscience and anti-discrimination laws and 45 C.F.R. Part 88 apply.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

12-19-2022

Date

Kelly Garcia

Signature of Authorized Official

Kelly Garcia - Director

Name and Title of Authorized Official (please print or type)

Iowa Department of Health and Human Services

Name of Agency Receiving/Requesting Funding

1305 E. Walnut St.

Street Address

Des Moines, IA 50310

City, State, Zip Code

Please mail form to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W. Room 509F
Washington, D.C. 20201

The Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf in lieu of mailing it to the address provided.

CCBHC Planning Grant Narrative Citations and References

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[3] https://humanrights.iowa.gov/cas/na

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[5] https://mhanational.org/sites/default/files/2022 State of Mental Health in America.pdf

[6] Ibid.

[7] Ibid.

[8] https://yourlifeiowa.org/sites/default/files/2021-06/Iowa%20Drug%20Trends%20June%202021.pdf

[9] Iowa Violent Death Reporting System Special Report on Suicide in Iowa, 2019

[10] https://namiiowa.org/iowa-must-act-to-alleviate-mental-health-care-deficit/

[11] https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-03-11-009.pdf

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[13] https://drugabusestatistics.org/teen-drug-use/#iowa

[14] https://www.iowaaces360.org/uploads/1/0/9/2/10925571/acesreport2020.pdf

[15] https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model

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[24] https://www.samhsa.gov/data/report/behavioral-health-barometer-iowa-volume-6

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[30] https://www.iowadatacenter.org/

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[35] https://www.treatmentadvocacycenter.org/browse-by-state/iowa

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