EXHIBIT A

Interim Settlement Agreement

This Interim Settlement Agreement ("Interim Agreement") is dated October 2, 2023, and concerns the civil action captioned *C.A. v. Garcia*, case number 4:23-cv-00009-SHL-HCA, United States District Court for the Southern District of Iowa (the "Litigation"). This agreement is between Defendant Kelly Garcia, in her official capacity as director of the Iowa Department of Health and Human Services ("Defendant" or "Iowa HHS") and Plaintiffs C.A, through their next friend P.A., C.B. through his next friend P.B., and C.C., through his next friend P.C., for themselves and those similarly situated ("Plaintiffs").

The purpose of this Interim Settlement Agreement is to establish a structure and process for the Parties to negotiate the terms of a Final Settlement Agreement. The settlement shall be designed to enable the Iowa Department of Health and Human Services to improve its delivery of intensive home and community-based mental health services (described in **Appendix A** of this Interim Agreement) to the members of the Defined Class. This Interim Agreement includes: (A) agreement as to the timing of compliance with the Interim Agreement and negotiation of Final Settlement; (B) an agreed-upon Implementation Plan; (C) an agreed-upon certification of the class and stay of litigation; (D) agreed-upon parameters related to the Final Settlement; (E) an agreement for the enforcement of this Interim Agreement; and (F) agreed-upon miscellaneous provisions governing this agreement.

The Final Settlement Agreement of the Litigation shall be subject to the approval of the United States District Court (the "Court") pursuant to Fed. R. Civ. P. 23 and other applicable federal law.

This Interim Settlement Agreement shall be subject to the Court's approval of an order modifying the Scheduling Order to reflect the continuance of litigation activity and certifying the class, as contemplated herein.

The Parties share the Goals and Principles, as they apply to the members of the Defined Class, set forth in **Appendix B** to this Interim Agreement, which shall guide and inform the Parties' implementation of this Interim Agreement, negotiation of a Final Settlement Agreement, and implementation of the terms of the Final Settlement Agreement.

A. Timing of Compliance with Interim Agreement and Negotiation of Final Settlement Agreement

1. The Implementation Plan identified in this Interim Agreement shall be accomplished on or before the 180th day following entry of the Court's order accepting this Interim Agreement.

2. Iowa HHS, while empowered to enter into and implement this Interim Agreement, does not have the legal authority to bind the Iowa General Assembly, which has the authority under the Iowa Constitution and laws to appropriate funds for, and amend laws pertaining to, the State's system of services for the Defined Class. Iowa HHS shall make all reasonable efforts to obtain funding and resources to fulfill the terms of this Interim Agreement. At least annually after Court approval of this Interim Agreement, and consistent with existing state budgetary practices and legal requirements, Defendants shall request state funds sufficient to effect the terms set forth in this Interim Agreement in connection with any budget, funding, or allocation request to the executive or legislative branches

of State government. Defendants shall also maximize all available federal funding opportunities. Before seeking a judicial remedy for non-compliance with this Interim Agreement, Plaintiffs shall comply with the dispute resolution procedures set forth in subsection F. Defendants submit to the enforcement of this Interim Agreement to the full extent permitted by law.

3. The Parties will use best efforts to negotiate a Final Settlement Agreement by July 1, 2024 and to continue implementation of the reforms outlined in the Interim Agreement.

4. Upon the execution of this Interim Agreement, the Parties shall establish a schedule for the Parties to meet and confer virtually, no less than monthly, to exchange information, including information relating to the status of Defendant's efforts under the Interim Agreement and input from Plaintiffs with regard to those efforts, and to negotiate the terms of the Final Settlement Agreement. The Parties shall share agenda items with one another seven days before the scheduled meeting date, if possible. Such meetings will be attended by Director Garcia and/or Director Matney or their Department designee(s). The Plaintiffs will make every effort to limit its fee requests to the number of representatives it has a good faith belief were reasonably necessary for attendance at the monthly meetings.

5. Upon execution of this Interim Agreement, the Parties shall:

    a. Establish the scope of and timelines for the exchange of information related to Defendant's compliance with the Interim Agreement; and

    b. Establish milestones for the negotiation of the Final Settlement Agreement by July 1, 2024, and place those milestones in a timeline.

6. The Parties shall make every effort to adhere to the established schedules and timelines.

7. Iowa HHS represents that prior to the filing of this lawsuit, Iowa HHS initiated managed care contract changes and program changes, some of which have been implemented prior to this Interim Agreement. Nevertheless, Iowa agrees to additional modifications to the contracts if necessary to implement this Agreement.

B. Implementation Plan

8. Iowa HHS shall develop a single, integrated implementation plan that will include all the components identified in this Section B (the "Implementation Plan") on or before the 180th day following the entry of the Court's order approving this Interim Agreement. Iowa HHS will regularly consult with Plaintiffs and the expert consultants in connection with the development of the Implementation Plan and will provide timely updates on its progress at the monthly meeting of the Parties. After the completion of the draft Implementation Plan, under the timeline described above, Plaintiffs shall have 30 days to provide written feedback on the draft Plan prior to their completion.

a. The Relevant Services

i. Iowa HHS's Implementation Plan will, in a manner consistent with best practices, include a comprehensive intensive service array/package for the Defined Class that will

include the following services (the "Relevant Services"): (a) intensive home and community-based services (IHCBS), as outlined in **Appendix A**, pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of the Medicaid Act (Section 42 U.S.C. §§ 1396a(a)(10)(A); 1396a(a)(43)(C); 1396d(a)(4)(B); 1396d(r)(1); 396d(r)(5)); and (b) Medicaid waiver services designed to ensure all members of the class receive services in the least restrictive setting appropriate to their needs, as outlined in **Appendix A.**

ii. The Implementation Plan will provide that the Relevant Services will be provided in accordance with each child's needs and will be available to children reasonably promptly and in the amount, scope, and duration necessary to meet the individual needs of eligible children and their families.

iii. The Implementation Plan will provide that eligibility for the package of the Relevant Services will be based on a statewide assessment utilizing a specific assessment tool appropriate to meet the needs of the Defined Class.

iv. As part of the Department's ongoing improvement prior to the filing of this action, Defendant obtained the assistance of two nationally recognized expert consultants, Mathematica and Health Management Systems (HMS) to provide guidance and consultation, based on data analyzed, on system design for the delivery of the Relevant Services to the Defined Class. That guidance and consultation will take into account the characteristics of the Defined Class and the scope of the need for the Relevant Services. This guidance and consultation is intended to ensure that sufficient capacity for the services is promptly established and these services and supports are available in a timely manner to all members of the Defined Class, including specialized services and supports for specific populations, which include, but are not limited to, BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ populations. Iowa HHS will use these expert consultants to analyze the utilization, penetration rates, and expenditures for mental health services and supports currently provided to Medicaid-eligible children in Iowa, including IHCBS and Children's Mental Health Waiver services, to identify potential gaps in services or difficulties in accessing services. The Department confirms and acknowledges that the experts identified have expertise in behavioral health services for children and home and community-based services.

v. With respect to Mobile Crisis Intervention and Stabilization Services (MCIS) identified in Appendix A, Section A (3), Iowa HHS will include a plan for MCIS in its Implementation Plan which ensures the provision of such services.

b. Beneficiary Information and Service Array

i. Iowa HHS's Implementation Plan will include, in a manner consistent with best practices, a plan for how it will better inform, educate, and involve members of the class, providers, and public child-serving agencies regarding design of, availability of, and eligibility for the Relevant Services.

c. Eligibility and Access to Behavioral Health

i. Iowa HHS's Implementation Plan will, in a manner consistent with best practices, detail how it will ensure that all persons conducting assessments regarding eligibility for the Relevant Services, including Managed Care Organizations (MCOs), use the same criteria for services and the same screening and assessment tools.

ii. Iowa HHS's Implementation Plan will also describe how the eligibility criteria, assessment tool(s), and utilization review criteria will be disclosed, including the processes, strategies, evidentiary standards, and other factors used to determine eligibility for or limitation of behavioral health services.

d. Service Delivery and Quality Improvement

i. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for providing all members of the class timely access to the Relevant Services.

ii. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for improving quality of Medicaid services and supports throughout the State. This will include a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to members of the Defined Class and their families.

iii. As part of the Department's ongoing improvement prior to the filing of this action, Iowa HHS has implemented a systematic rate review system for providers that it will continue to follow. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, additional plans for improving adequate provider capacity throughout the State. Adequate provider capacity consists of a sufficient number of quality providers with capacity, appropriate caseloads, and expertise to provide all necessary Relevant Services to members of the Defined Class, including specific populations having specialized needs, which include, but are not limited to, BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ populations.

e. Service Delivery in the Least Restrictive Setting

i. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for providing all members of the Defined Class with medically necessary mental and behavioral health services in the least restrictive setting appropriate to their needs.

ii. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for preventing inappropriate and segregated placements, such as psychiatric hospitals, emergency rooms, or psychiatric residential treatment facilities for children with mental and behavioral disorders and children experiencing mental health crises, including specific populations having specialized needs, which include,

but are not limited to, BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ populations.

iii. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for ensuring that members of the Defined Class discharged from residential or institutional settings, or other out-of-home placements, receive the Relevant Services needed to remain at home and in the community and to prevent readmissions to these institutions or residential settings.

f. Data Collection

i. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for collecting, tracking, analyzing, and using claims and encounter data, utilization data, and expenditure data to determine how well the system is performing (*i.e.*, to determine if Defendant is properly providing members of the Defined Class with Relevant Services, including in the most integrated settings appropriate to their needs, and evaluate whether children are achieving improved outcomes).

ii. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for making public user-friendly data detailing, among other items: the characteristics of children screened/assessed and determined eligible for Relevant Services, the specific behavioral health services children are receiving, how much of each service they are receiving, who is receiving these services (*e.g.*, child welfare involved children, *et al.*), the timeliness with which children receive each service, the locations in which children receive mental health services, the availability of mental health services in the least restrictive setting appropriate to children's needs, the scope and intensity (*e.g.*, how many hours per month and how long) of each of the services, the outcomes for children and families, average monthly cost per child, and average monthly service utilization per child.

g. Reporting and Monitoring of Implementation Plan

i. Iowa HHS's Implementation Plan will develop, in a manner consistent with best practices, a plan for identifying, gathering, analyzing, and using available, reliable, and relevant data from a variety of sources to adequately monitor the behavioral health system; and for using tracking and quality management tools to measure access to care, assess adequacy of Relevant Services capacity, evaluate and continuously improve outcomes, and ensure quality throughout the State. The Implementation Plan shall address access to the data and shall assign responsibility to review and analyze the data at the individual child service, agency, and statewide levels to ensure adequate capacity and quality of services, establish and maintain accountability, and monitor required systemic improvements.

ii. Iowa HHS has developed and will continue to maintain a publicly available data dashboard, updated quarterly. Iowa HHS will ensure that the dashboard shows

statewide performance concerning children's behavioral health measures, including the increase in utilization of the Relevant Services. The dashboard will provide specific claims or encounter data on the provision of IHCBS.

C. Certification of the Class and Litigation Stay

9. Defined Class.

a. Defendant consents to the certification of the class defined as all Medicaid-eligible children in the State of Iowa under the age of twenty-one, (i) who have been determined by a licensed practitioner of the healing arts as having a serious emotional disturbance, not attributable to an intellectual or developmental disability, and (ii) for whom there is an assessment that intensive home and community-based services are needed to correct or ameliorate their condition.

b. Licensed practitioner of the healing arts, as used in this Interim Agreement, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital or family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

c. Serious emotional disturbance means a "diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American psychiatric association that results in a functional impairment." Iowa Code § 225C.2.2.

10. Subject to approval of the Court and the Court's adjustment of other litigation deadlines, the Parties agree that formal discovery will be stayed until July 1, 2024. However, the informal exchange of information related and necessary to the implementation of this Interim Agreement is expected. The Parties shall have an obligation of candor to each other. The Parties reserve the right to present any discovery disputes to the Court during the stay period.

11. Upon the execution of this Interim Agreement, the Parties shall submit to the Court a joint motion for an order regarding enforcement of this Interim Agreement, certifying the class and staying formal discovery as set forth above. The Parties shall cooperate in connection with obtaining such an order from the Court.

12. The Parties shall submit a joint status report to the Court on December 15, 2023, March 15, 2024, and June 14, 2024, reflecting the status of the Parties' compliance with the Interim Agreement and negotiation of the Final Settlement Agreement.

13. Because this Interim Agreement is not a final settlement of the claims set forth in the Litigation and does not bind the members of the class, the Parties believe that notice to the Defined Class and a hearing on the proposed order are not required under Fed. R. Civ. P. 23 prior to entry of an Order regarding enforcement of this Interim Agreement. Accordingly, the Parties will ask the Court to enter its Order herein without formal notice to the Defined Class, other than notice to the individual class

representatives in this case. Should the Court determine that notice to the broader Defined Class is required, the Parties will provide said notice as directed by the Court.

14. Except as otherwise noted, the terms of this Agreement shall not take effect until the Court issues its Order regarding enforcement of this Agreement. The Court shall retain jurisdiction of the Litigation during the term of this Interim Agreement.

15. Nothing in this Interim Agreement shall limit the ability of any individual Plaintiff or putative class member to pursue any legal or administrative remedies during the pendency of this case.

16. Nothing in this Interim Agreement shall be deemed to limit the ability of Disability Rights Iowa to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, *et seq.*, and the regulations promulgated thereto, 42 C.F.R. § 51 *et seq.*, the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, *et seq.*, and the regulations promulgated thereto, 45 C.F.R. § 1326 *et seq.*, the Rehabilitation Act Amendments of 1992, 29 U.S.C. § 794e.

D. The Final Settlement Agreement

17. Any Final Settlement Agreement will reflect the Parties' mutual agreement to the Implementation Plan developed under the Interim Agreement and require the Defendant to implement the agreed-upon Implementation Plan and meet negotiated performance requirements, including for the delivery of the Relevant Services to members of the Defined Class. The Final Settlement Agreement shall also contain an enforcement mechanism, including the appointment of a mutually acceptable independent monitor to measure and report on the performance requirements specified in the Final Settlement Agreement, and shall be incorporated into a court-ordered Consent Decree.

18. Upon entry of a Final Settlement Agreement enforceable through a court-ordered Consent Decree, Plaintiffs shall be deemed a prevailing party and the reasonableness of attorney fees, costs and expenses awarded may include a determination of the level of success and benefit achieved by Plaintiffs in connection with this Litigation. Plaintiffs can also seek reasonable attorneys' fees and costs for monitoring and enforcement of a Final Settlement Agreement and Consent Decree.

19. The terms of the Final Settlement Agreement will be subject to Court approval, including preliminary approval and a fairness hearing prior to final approval, and will be incorporated into the terms of an appropriate court order. The Court shall retain jurisdiction to enforce the terms of the Final Settlement Agreement and associated court order.

20. In the event no Final Settlement Agreement is entered into by July 1, 2024, litigation activities shall resume upon the expiration of the stay, unless the Parties mutually agree to extend the stay, and such an extension is approved by the Court.

E. Enforcement

21. This Interim Agreement contains obligations that shall be binding upon the Parties, and which may be enforced by the Court.

F. Dispute Resolution

With regard to all provisions in this Interim Agreement, the following dispute resolution process shall apply:

22. Prior to seeking judicial remedies for a violation of this Interim Agreement, Class Counsel shall notify State Defendants in writing if they believe State Defendants are in violation of this Interim Agreement and shall state with specificity the alleged non-compliance.

23.. The Parties shall engage in a 30-day period of good faith negotiations in an effort to resolve the alleged violation, which period may be extended on consent of the Parties. If the matter is not resolved, it may be presented to the Court for resolution.

24. If Plaintiffs allege that a violation of this Interim Agreement has caused or threatens to cause an imminent danger of substantial harm to the members of the Defined Class, Plaintiffs may bypass these dispute resolution provisions and directly present a matter to the Court for resolution. In such case, Plaintiffs shall give emergency notice of their allegations to State Defendants.

G. Other Provisions

25. The materials contained in Appendix A and Appendix B are included in and fully incorporated into this Interim Agreement as if fully set forth herein.

26. This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Parties hereto.

27. The Parties have participated and had an equal opportunity to participate in the drafting and/or approval of this Agreement. No ambiguity shall be construed against any party based upon a claim that the party drafted the ambiguous language.

28. Signors of this Agreement represent and warrant that they have full power and authority to enter into this Agreement and to carry out all actions required of them to the extent allowed by law. Each of the signors warrants that he/she has fully read and agrees to all the terms and conditions contained herein.

29. This Agreement may be amended by mutual agreement of the Parties and approval of the Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the Parties, and approved by the Court. The Parties further agree to work in good faith to obtain Court approval of necessary amendments or modifications.

30. This Agreement shall inure to the benefit of and be binding upon the legal representatives and any successor(s) of Plaintiffs and Defendants.

31. If, for any reason, the Court does not approve this Interim Agreement the parties shall make good faith efforts to modify the Agreement so as to gain judicial approval of this Agreement.

32. This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail which shall be deemed the same as an original signature.

FOR AND ON BEHALF OF DEFENDANT:

By: _____ Dated: 10/2/2023
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By: _____ Dated: 9/29/23

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APPENDIX A

Intensive Child and Adolescent Services, the "Relevant Services" for the Defined Class

A. Intensive Home and Community-Based Services

1. Intensive Care Coordination

Intensive Care Coordination (ICC) includes facilitating assessment, care planning, coordination of services, authorization of services, and monitoring of services and supports to address children's health conditions by a single, consistent care coordinator.

Intensive Care Coordination provides:

- A single point of accountability for ensuring that medically necessary Medicaid services are accessed, coordinated, and delivered in a strength-based, individualized, family-driven, child-guided culturally and linguistically relevant manner;
- Services and supports that are guided by the needs of the child;
- Facilitation of a collaborative relationship among a child, the family, and child-serving systems;
- Support for the parent/caregiver in meeting the child's needs;
- A care planning process that ensures that a care coordinator organizes and matches care across providers and child-serving systems to allow the child to be served in the home and community; and
- Facilitated development of an individual's care planning team (CPT). Teaming is a process that brings together individuals selected by the child and family who are committed to them through informal, formal, and community support and service relationships. ICC will facilitate cross-system involvement and a formal child and family team.

ICC service components consist of:

Assessment: Iowa HHS will implement its care planning team process, which includes

- completing a strengths-based, needs driven, comprehensive assessment to organize and guide the development of a Care Plan and a risk management/safety plan;
- an assessment process that determines the needs of the child for medical, educational, social, behavioral health, or other services;
- an ICC that may also include the planning and coordination of urgent needs before the comprehensive assessment is completed;

- further assessments that are provided as medically necessary and in accordance with best practice protocols.

Planning and Development of a Family-Driven, Child-Guided, Person-Centered Plan (PCP): Iowa HHS will maintain a family-driven, child-guided, person-centered planning process, which includes:

- having the care coordinator use the information collected through an assessment, to convene and facilitate the CPT meetings;
- having the CPT develop a child-guided and family-driven PCP that specifies the goals and actions to address the medical, educational, social, mental health, and other services needed by the child and family; and
- ensuring that the care coordinator works directly with the child, the family, and others significant to the child to identify strengths and needs of the child and family, and to develop a plan for meeting those needs and goals.

Crisis Planning. The Care Coordinator will provide crisis planning that, based on the child's history and needs, (a) anticipates the types of crises that may occur, (b) identifies potential precipitants and creates a crisis plan to reduce or eliminate them, and (c) establishes responsive strategies by caregivers and members of the child's team to minimize crises and ensure safety;

Referral, monitoring, and related activities: Iowa HHS will require that the care coordinator:

- works directly with the child and family to implement elements of the PCP;
- prepares, monitors, and modifies the PCP in concert with the CPT and determines whether services are being provided in accordance with the PCP; whether services in the PCP are adequate; and whether there are changes in the needs or status of the child and, if so, adjusts the PCP as necessary, in concert with the CPT; and
- actively assists the child and family to obtain and monitor the delivery of available services, including medical, behavioral health, social, therapeutic, and other services.

Transition: Iowa HHS will require the care coordinator to:

- develop a transition plan with the CPT, and implement such plan when the child has achieved the goals of the PCP; and
- collaborate with the other service providers and agencies on behalf of the child and family.

Settings: ICC may be provided to children living and receiving services at home and in the community, including foster care placements, as well as to children who are currently in a hospital, group home, or other congregate or institutional placement as part of discharge or transition planning. Notwithstanding the foregoing, ICC will not be provided to children in juvenile detention centers.

2. Intensive In-Home and Community Therapeutic Services (IHCTS)

Intensive In-Home and Community Therapeutic Services (IHCTS) are individualized, strength-based interventions to correct or ameliorate behavioral health conditions that interfere with a child's functioning. Interventions help the child to build skills necessary for successful functioning in the home and community and improve the family's or caregiver's ability to help the child successfully function in the home and community.

IHCTS are delivered according to a care plan developed by the CPT. The CPT develops goals and objectives for all life domains in which the child's behavioral health condition causes impaired functioning, including family life, community life, education, vocation, and independent living, and identifies the specific interventions that will be implemented to meet those goals and objectives.

The goals and objectives seek to maximize the child's ability to live and participate in the community and to function independently, including through building social, communication, behavioral, and basic living skills. Providers of IHCTS should engage the child and other family members or caregivers in home and community activities where the child has an opportunity to work towards identified goals and objectives in a natural setting. The provision of IHCTS does not include the prescription of medications, including psychotropic medications or hormone-based therapies.

Phone contact and consultation may be provided as part of the service.

IHCTS include, but are not limited to:

- Educating the child's family about, and training the family in managing, the child's needs;
- In-home functional behavioral assessments, as needed;
- Behavior management, including developing and implementing a behavioral plan with positive behavioral interventions and supports, modeling for the child's family and others how to implement behavioral strategies, and in-home behavioral aides who assist in implementing the behavior plan, monitoring its effectiveness, and reporting on the plan's effectiveness to clinical professionals;
- Therapeutic services delivered in the child's home and community, including but not limited to therapeutic interventions such as (a) individual and/or family therapy, and (b) evidence-based practices (*e.g.*, Family Functional Therapy, Multisystemic Therapy, Trauma-Focused Cognitive Behavioral Therapy, etc.). These services:
    - Improve self-care, including addressing behaviors and social skills deficits that interfere with daily living tasks and avoiding exploitation by others;
    - Improve self-management of symptoms, including assisting with self-administration of medications;

- Improve social functioning, including addressing social skills deficits and anger management;

- Support the development and maintenance of social support networks and the use of community resources;

- Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job;

- Support educational objectives, including identifying and addressing behaviors that interfere with succeeding in an academic program in the community; and

- Support independent living objectives by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

Settings: IHCTS may be provided to children living and receiving services at home and in the community, including foster care placements, as well as to children who are currently in a hospital, group home, or other congregate or institutional placement as part of discharge or transition planning. Notwithstanding the foregoing, IHCTS will not be provided to children in juvenile detention centers.
Providers: IHCTS are provided by a qualified provider.

3. Mobile Crisis Intervention and Stabilization Services (MCIS)

Mobile crisis services (MCIS) include crisis planning and prevention services, as well as face-to-face interventions that support the child in the home and community.

Services include, but are not limited to:

- Responding to the immediate crisis and assessing child and family safety, and what kinds of resources are available to address immediate problems.

- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions;

- Referral and coordination with (a) other services and supports necessary to continue stabilization or prevent future crises from reoccurring, and (b) any current providers and team members, including the care coordinator, therapists, family members, primary care practitioners, and school personnel; and

- Post-crisis follow-up services (stabilization services) in compliance with state regulations and timeframes.

Settings: During a crisis, MCIS should be provided at the location where the crisis is occurring, including the home (biological, foster, relative, or adoptive) or any other setting where the child is naturally located, including schools, recreational settings, child care centers, and other community settings.

Availability: MCIS are available 24 hours a day, seven days a week, 365 days a year.

Providers: Pre-crisis planning and post-crisis services are typically provided by qualified providers drawn from members of the CPT as part of the provision of ICC and IHTS. During the crisis, MCIS are provided by a trained and experienced mobile crisis professional or team. Sufficient MCIS providers to meet the expected needs of members of the Defined Class should be available. MCIS providers may include paraprofessionals.

B. Waiver Services to Ensure Placement in Least Restrictive Setting

Additional Medicaid waiver services are used in conjunction with covered EPSDT services to support children with serious emotional disturbances and to help maintain them in their homes and communities and avoid higher levels of care and out-of-home placements. These services are currently authorized through a waiver under Section 1915(c) of the Social Security Act, allowing Iowa to spend federal Medicaid dollars on these services. Like IHCBS, these services improve the family's or caregiver's ability to help the child successfully function in the home and community, and help the child to build skills necessary for successful functioning in the home and community. Such services could include, but are not limited to, respite care and other services or supports not required to be covered under Medicaid EPSDT provisions.

Children receiving such services must have an individualized service plan (ISP) developed collaboratively with an interdisciplinary team (IDT). This plan documents the agreed upon goals, objectives, and service activities. The ISP must be reviewed and updated annually. The interdisciplinary team (IDT) consists of the child, the child's parents or legal guardians, case manager, mental health professionals, and any other persons that the child and family choose to include. The team meets to plan the supports a child and family need to safely maintain the child in the home.

APPENDIX B

Goals and Principles

1. The Goals of the Interim Agreement include, as they pertain to the members of the Defined Class:

    a. Identifying the intensive home and community-based service array (hereinafter referred to as the "Relevant Services") to be provided. The Relevant Services are described generally in Appendix A.

    b. Identifying the population to be served, the procedures for determining eligibility, how Medicaid-eligible beneficiaries access mental health care services and supports, the locations in which Medicaid beneficiaries receive these services and supports, and how to monitor and enforce the fulfillment of the Defendant's obligation to provide these services and supports.

    c. Establishing practices and procedures to promote improved collaboration and coordination by child-serving agencies, state agencies, counties, and providers that deliver care to Medicaid-eligible children with mental or behavioral health disorders, thereby improving the effectiveness of services to, and the outcomes of, families and children. Improving collaboration will also reduce duplication and waste, and lower costs.

    d. Establishing practices and procedures to reduce the fragmentation of services.

    e. Establishing consistent statewide screening, assessment, and referral procedures that will facilitate access to the Relevant Services, regardless of entry point, for all Medicaid-eligible children with mental or behavioral health disorders. It is the expectation of the Parties that a Medicaid-eligible child with mental or behavioral health disorders will be appropriately screened and, if necessary, assessed for the Relevant Services regardless of the initial point of contact, after which the child will be referred to the appropriate agency for provision of the Relevant Services.

    f. Providing the foundation for the statewide provision of behavioral health services consistent with the Principles under this Interim Agreement and developing and maintaining a comprehensive service array in order to provide members of the class with timely access to medically necessary and other home and community-based mental health services.

    g. Ensuring that Medicaid-eligible children receive mental health services in the most integrated setting appropriate to their needs and are free from serious risks of segregation and institutionalization, including the unnecessary use of out-of-home placements.

    h. Making systemic changes to ensure that the services and supports that are necessary to maximize the success and development of Medicaid-eligible children and adolescents with behavioral health disorders into healthy and independent adults are timely provided.

    i. Ensuring that children experiencing mental health crises receive an appropriate and effective response centered on addressing the underlying mental health issues at the place where the

child is located, and are not being relegated to law enforcement personnel and hospital emergency rooms.

j. Identifying and developing quality management tools and measures to monitor, provide, and improve quality of care, and to provide transparency and accountability to, and the involvement of, families, children, providers, advocacy organizations, and others with interest in the provision of behavioral health services.

k. Identifying and developing plans to address the specific service deficiencies that affect underserved communities, including specific populations having specialized needs, which include, but are not limited to, BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ populations.

l. Identifying and developing measurable and enforceable standards to determine whether the State is fulfilling its obligation to provide necessary services and supports to Medicaid beneficiaries.

m. Identifying and developing reforms that maximize the effectiveness and efficiency of state resources in accordance with the Commitments outlined in this Interim Agreement.

2. The Parties shall be guided by the following Principles in connection with their implementation of this Interim Agreement, negotiation of a Final Settlement Agreement, and implementation of the terms of the Final Settlement Agreement. These broad Principles have been developed by the National Wraparound Initiative and describe a set of child and family-centered values and principles that shall inform and guide the management and delivery of the Relevant Services:

a. **Child Centered and Family Driven**: Family and child voice, choice, and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-driven and child-guided from the first contact with or about the family or child. Services and interventions also seek to reduce the burden placed on parents and caregivers in arranging, seeking out, and coordinating services.

b. **Team-based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach, referred to as a "child and family team." Team members are chosen in conjunction with the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.

c. **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of relationships (*e.g.*, friends, neighbors, community, and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency. However, implementation of the plan is not dependent on the availability of natural supports. Parents, guardians, and caregiver support and cooperation are key to the successful delivery of services to the Defined Class members in the least restrictive setting.

d. **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in child welfare, juvenile justice, behavioral health and developmental disabilities, substance use, primary care, and education systems. Delay in service should not occur as a result of questioning who is the responsible payor.

e. **Home and Community-based**: Children are first and foremost safely maintained in, or returned to, their homes or the most family-like setting. Services and supports take place in the most inclusive, most integrated, most responsive, most accessible, and least restrictive or most family-like setting appropriate based on the needs of each child.

f. **Culturally Relevant**: Services are culturally relevant and respect the values, preferences, beliefs, culture, and identity of the child/adolescent, family, and community, including specific populations having specialized needs, which include, but are not limited to, BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ populations.

g. **Individualized**: Services and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered to meet changing needs and goals.

h. **Strengths-based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, and the strengths of the community and other team members.

i. **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible to overcome setbacks and achieve goals and outcomes. Safety, stability, and permanency are priorities.

j. **Unconditional Care**: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the services are assessed to be no longer necessary or the family indicates that they are no longer required.