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How Gaps in Iowa's Behavioral Health and Disability Systems Lead to Crisis, Hospitalization, and Incarceration

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Appendix A. Codebook

CODE	CODE DESCRIPTION
Integration & Segregation Risk	
A1 Unnecessary Institutionalization	Individual remains in hospital, nursing facility, adult home, SRC/ICFIID or similar setting *despite community placement being clinically appropriate and feasible*; caused by missing services, hours, housing, or transitions.
A2 Serious Risk of Institutionalization	Community placement is unstable due to missing/undelivered services (e.g., staffing failures, unavailable providers), creating foreseeable need for institutionalization. Include cases where professionals explicitly acknowledge predictable harm or foreseeable institutionalization if services remain unavailable.
A2a Foreseeable Deterioration When Continuing Current Plan	Providers explicitly state foreseeability of harm if the person remains in the current setting. (e.g., “He will not live much longer.” “We see this every day.”)
A3 ER Boarding / ED Cycling	Repeated ER visits or prolonged ED stays caused by lack of crisis alternatives, stepdown programs, or community supports.
A3a ED Boarding (≥24h)	Extended ED stay beyond threshold (e.g., ≥24 hours); indicates system inability to provide integrated setting.
A3b ED High Utilizer (≥6 visits/yr)	Frequent ED use meeting defined threshold due to unmet needs or inadequate community supports.
A3c ED as De Facto Placement	Chronic, high frequency use where ED substitutes for residential care. Cross-code with C6 & I1.
A4 Jail Reliance for Clinical Needs	Jail/custody used as de facto placement (intentionally or by default) for behavioral/clinical issues because community/integrated services are unavailable. Jail is used not only because community supports are unavailable but also when systems intentionally rely on arrest to manage disability driven behavior. Examples of “Carceral stabilization:” medication adherence only achieved in jail; food/housing/structure available only in custody
A4b. Jail as Default Placement Despite Known Disability Needs	Captures use of jail not merely due to absence of services but intentional reliance despite clinical inappropriateness.
A5 Out-of-state / No Placement Available	No provider accepts individual, including “blacklisting”; results in OOS placement or unnecessary continued institutionalization.
Access & Service Delivery Failures	
B1 Authorized vs. Delivered Gap	Approved HCBS/PDN hours or services are not delivered (e.g., “no staff,” agency discharge, missed visits).
B1a PDN/Skilled Nursing Gap	Non-delivery of skilled nursing/PDN hours approved for community living.
B1b HCBS Aide/Supports Gap	Non-delivery of homemaker/personal assistance/support hours.
B2 Service Denials/Reductions	State/MCO denies or reduces medically necessary services, often linked to increased segregation risk. Denials based on diagnosis hierarchy / gatekeeping / misclassification (“primary SUD,” excluding co-occurring cognitive impairment) and payer denials overriding clinical judgment. Crosscode- with **B8** and **G11**.

B2a Diagnostic Gatekeeping / Misclassification	Diagnoses are selectively used to block access. E.g., denial of IMPACT because SUD was “primary,” discounting cognitive impairment, and categorical exclusions (ACT, ID waiver, housing vouchers)
B3 Waiver Waitlists / Delays	Extended waits for HCBS waiver slots (including emergency slots) that prolong segregation or risk thereof.
B4 Coverage Gaps / Ineligibility	Medicaid or other coverage lapses (e.g., after incarceration) prevent access to required community services.
B5 Discharge / Transition Failures	Breakdowns in transition planning or failure to ensure continuity during provider/MCO changes.
B5a Transitions as a Service Need	(e.g., structured stepdown planning with time limited higher supports). Cross-code with **C9**.
B6 Provider Refusal / Blacklisting	Providers refuse to accept individuals due to complexity, behavioral profile, history, perceived “liability,”- foreclosing community placement.
B6b Provider Dropoff / Abandonment Due to Perceived “Liability”	Post-admission drop-off for ‘liability’ and reputational refusals. Descriptions of providers dropping the client because they were “too complex” or “a liability.” Different from refusal; captures termination after acceptance. Cross-code with C7 and C12
B7 Benefit Churn / Coverage Instability	Medicaid or benefits lapse (e.g., post incarceration, work requirements) blocks access to services.
B8 Placement Exclusions—Criminal History / Behavioral	Rejection from housing/treatment due to criminal record or behavioral reputation, not current clinical risk.
B9 Discharge to Homelessness	Discharges from ED/hospital without a viable plan lead directly to street/shelter despite known incapacity.
B10 Intake/Engagement Barriers (Lost Phone / No Address / Appointment Friction)	Practical barriers (no phone, transport, reminders) repeatedly derail engagement; systems fail to accommodate.
B11 Program Rules Misfit (Requirements Incompatible with Disability)	Rules (e.g., 40hour work requirements, abstinence only) directly conflict with disability presentation and cause termination/exclusion.
System Drivers & Policy Design	
C1 Workforce Shortage / Training Mismatch	Insufficient or inadequately trained workforce undermines ability to deliver community services. Includes trauma-informed deficits and behavioral acuity training gaps that make placements fail even when authorized.
C2 MCO Oversight Failure / Network Inadequacy	MCO/state fails to enforce contracts, ensure network adequacy, or address known non-delivery.
C2a Network Adequacy Gap	Provider network too limited to meet authorized needs.
C2b Contract Enforcement Gap	Lack of sanctions or corrective action when non-delivery is known.
C3 Program Time Caps / Rigid Limits	Arbitrary program length caps or rigid durations that prematurely discharge individuals or destabilize community tenure.

C4 Fragmentation (Co-Occurring Siloing)	MH/SUD or MH/IDD systems deflect responsibility, causing gaps and revolving crises. Include situations where competing systems (MH, SUD, IDD) each reject the individual, leading to complete service voids.
C4a MH/SUD/IDD Fragmentation Resulting in "No Door"	Examples of systems deflecting responsibility due to cooccurring disorder conflicts. When siloing means *no system* takes responsibility.
C5 Housing Scarcity / Instability	Insufficient housing stock or inadequate tenancy supports resulting in failed housing or segregation risk.
C5a Housing Mismatch (Placement Type Predictably Destabilizing)	E.g., PSH accelerates decline; no "middle ground" options; community placements that worsen functioning. For situations where available housing is *inherently* inappropriate.
C6 Payment Incentive Misalignment	FFS or payer rules reward ED volume/short stays over sustained community stabilization; insurance denial overrides clinical judgment.
C7 Risk/Liability Avoidance Culture	Providers or programs avoid higher acuity clients or discharge early to minimize perceived liability.
C8 Information Silos / Data Fragmentation	Dispatch, ED, shelters, MCOs lack shared data; "snapshot" assessments miss longitudinal risk.
C9 Continuum Gap / No Middle Tier	Lack of supervised, nonpunitive, stepdown/step-up placements between hospital/jail and PSH/outpatient. (E.g., locked/semi locked stabilization, staffed sober living with cognitive supports). Cross code B5a
C10 Consent/Privacy (HIPAA) Misinterpretation	Over restrictive interpretations block coordination even when legally permissible, impeding safe discharge and integration.
C11 AOT Used as Policy Substitute for Capacity	System reliance on AOT to compensate for missing residential capacity or case intensity. (Cross-code with G11 and I5.)
C12 Reputational Bias / "Malingering" Labels	Historic chart language follows clients and forecloses services regardless of current assessment.
C13 Equity & Disparate Impact	Structural features amplify risk for specific populations (e.g., racialized safety risk, policing patterns). Flag for policy remedies.
Person-Centered Planning & Choice	
D1 Person-centered Planning Deficit	Absence of genuine person-centered planning; plans do not reflect preferences or individualized needs.
D2 Informed Choice Limitations	Individual/guardian lacks accessible, accurate, practical information about community options (choice becomes nominal). Include cases where cognitive impairment negates ability to meaningfully choose but systems treat refusal or disengagement as preference.
D2a Capacity Based Limits to Choice / Misinterpretation of Choice	When systems rely on "choice" despite clear evidence of impaired capacity. Emphasize that nominal consent at discharge does not equal meaningful choice when deterioration is foreseeable. Cross-code with H5
D3 Exploitation Risk in Supposedly 'Independent' Settings	Captures safety risks unique to unsupervised environments.
Outcomes & Harms	

E1 Clinical Deterioration / Safety Risks	Worsening clinical outcomes linked to service failures (e.g., rapid readmissions, cycling).
E1a Preventable Cyclical Deterioration (Revolving Door)	Distinguish from general deterioration; focus on preventability. (e.g., repeated relapse, ED utilization, incarceration cycles driven by service gaps)
E2 Criminal Legal Exposure	Criminal legal involvement resulting from missing services (not criminal intent). Criminal involvement is *instigated by service failures* and the criminalization is tied to disability driven behaviors, not criminal intent.
E2a Criminalization of Disability Symptoms	When disability driven behaviors are treated as criminal acts. (Arrests for toy weapons, fear-based responses, impulsivity driven by cognitive impairment, misinterpreting social cues)
E3 Economic Inefficiency / Misallocated Spend	Institutional costs exceed cost-effective community alternatives (e.g., $1,000/day hospital vs. $700 rent). Cross-code with **G13** when cost specifics are documented.
E4 Caregiver/Familial Strain	Burden or impossible choices families face because of system gaps.
E5 Mortality / Severe Injury	Death or serious harm plausibly tied to service failure (e.g., exposure death after repeated ED cycling).
E6 Homelessness as System Outcome	Homelessness results from discharge decisions, denials, or capacity gaps (not "choice").
Remedies & Workarounds (Observed or Proposed)	
F1 Supported Housing Need / Remedy	Need for supported housing or evidence housing expansion prevents institutionalization (as in Kansas).
F2 Crisis Services / ACT / Mobile Teams	Mentions of ACT, mobile crisis, crisis stabilization as required alternatives to ER/jail.
F2a ACT (Assertive Community Treatment)	Intensive community-based team needed or referenced.
F2b Mobile Crisis	Onsite crisis intervention/stabilization needed or referenced.
F2c Crisis Stabilization Beds	Short-term bed-based stabilization required/used.
F3 Supported Employment / Day Supports	Employment or day programs used or needed to stabilize community tenure.
F4 Interim Supports / Reasonable Modifications	Bridge supports during waitlists, transitions, or shortages to avoid segregation.
F4a Missing "Middle Ground" Services (Cognitive support + SUD support + 24/7)	Important structural barrier for Olmstead claims. (Need for step-up/ step-down models not available in Iowa)
F5 MCO Enforcement / Sanctions Remedy	Need for stronger contract enforcement, oversight, sanctions, or dashboards.
Evidence/ Legal Elements	
G1 Clinical Approval for Community Placement	Evidence provider/professional deemed community placement appropriate (legal anchor).

G2 Authorization Documented	Service/hours formally approved (HCBS/PDN).
G3 Non-Delivery Documented	Missed visits, “no staff,” or documented service non-delivery.
G4 Denial/Appeal/Grievance Evidence	Documentation of denials/reductions, letters, appeal results.
G5 State/MCO Knowledge Noted	State/MCO aware of gaps or failures but did not correct.
G6 Waitlist Duration	Time on HCBS waitlist or emergency wait.
G7 Plan & Pace / Working Plan Reference	Evidence of benchmarks, timelines, funding—or gaps in Iowa's plan/pace obligations.
G8 Foreseeability Evidence	Provider/agency statements or documentation explicitly predicting deterioration, harm, or institutionalization if the status quo continues. Evidence showing that providers, agencies, or system actors explicitly recognized that the individual faced predictable deterioration, increased risk of institutionalization, worsening health, or death if current services/settings continued unchanged.
G9 System Knowledge of Mismatch / Lack of Alternatives	Evidence that state actors, MCOs, or service providers knew that the services offered/available did not match the individual’s needs, or knew that no appropriate options existed, yet failed to take corrective action.
G10 Guardianship/ SDM Bottleneck Evidence	Documentation of multiyear delays, waitlists, or procedural barriers in guardianship or other supported decision-making (SDM) that block access to services requiring surrogate consent. *Example:* Guardianship projected at ~2 years (1 year court + 1 year waitlist), preventing discharge or access to housing/benefits.
G11 AOT as Substitute Evidence **G12 Disparate Impact / Racialized Risk Evidence**	Evidence that Assisted Outpatient Treatment (AOT/PACT) is used as a **workaround** for missing residential/stepdown capacity, rather than part of a sufficient continuum. Notes indicating risk is racialized (e.g., concern about “wandering into the wrong yard”) or outcomes differ across groups. Use as a flag for equity analysis.
G13 Cost Differential / Inefficiency Evidence	Concrete cost references contrasting ED/jail/hospital vs. community alternatives, or payer decisions overriding clinical judgment.
Capacity, Insight, & Decision-Making Constraints	
H1 Impaired Judgement/ Executive Functioning	Evidence that the individual struggles with planning, organizing, understanding consequences, or regulating behavior in ways that affect their ability to live safely in the community. Planning/organization/consequences deficits undermine safe community living. *Examples:* Inability to manage hygiene, appointments, home safety; executive dysfunction causing benefits lapses.
H2 Inability to Assess Personal Safety / Exploitation Risk	Information indicating the person cannot recognize or appropriately respond to dangerous situations, exploitation, or harm in community settings.
H3 Low Insight into Disability/ Need for Support	Individual lacks awareness of the nature of their disability, supports required, or consequences of declining services. Limited illness awareness or support needs; refusal and disengagement tied to symptoms.

H4 System Misinterpretation of Capacity	When decisionmakers treat the individual as having capacity to choose independent living or service refusal, despite evidence of impaired judgment, cognition, or understanding. (e.g., viewing refusal as competent choice). Systems treat refusal/independence as meaningful "choice" despite evidence of impaired capacity. Discharging to homelessness because the person "chooses" it; probation framed as willful noncompliance.
H5 Fluctuating Capacity (Cycling Intoxication/Sobriety	Capacity varies predictably (e.g., intoxicated vs. sober), but systems lack durable plans that account for fluctuation. *Example:* ED: incapacitated when intoxicated (hold), then "capacitated" when sober → discharged → quick relapse loop.
Olmstead Red Flags	
I1 Patterned Crisis Utilization	Repeated, predictable cycles of hospitalizations, ED visits, EMS calls, arrests, or jail stays due to service gaps/ failures.
I2 Predictable Harm Not Acted Upon	Situations where providers foresee deterioration or danger (relapse/ harm/ death), but no alternative or corrective plan/action/ placement is implemented.
I3 Mismatch between Need and Available Services	Cases where the available service setting (e.g., PSH, independent apartment, emergency shelter) is clearly clinically inappropriate and worsens outcomes, yet used by default due to lack of alternatives.
I4 Known Alternatives Not Offered	Evidence that clinically appropriate or safer alternatives exist (or are known to providers) (Examples include ACT/step down/residential) but are blocked/ not pursued due to capacity limits, payer rules, funding barriers, diagnostic gatekeeping, or siloing.
I5 AOT Reliance in Lieu of Placement	AOT functions as containment because appropriate residential/locked/semi locked options do not exist.
I6 Guardianship / SDM Bottleneck	Lack/delay of guardian or SDM prevents access to integrated services or safe discharge.
I7 Diagnostic Gatekeeping / Labels as Exclusion Tools	Diagnoses (SUD "primary," ODD/personality, "malingering") used to exclude from MH/IDD supports.
I8 Criminal History / Behavioral Exclusions	Housing/treatment exclusion solely due to prior charges or reputational bias, despite clinical appropriateness.
Legal Foundations, Violations, & Enforcement Failures	
J1 ADA Title II Integration Mandate Triggered	Interview data shows segregation, risk of institutionalization, or denial of access to public programs/services by a state or local government. Use when: The barrier is caused by state agencies, county entities, public hospitals, jails, courts, etc. Service failures impede equal participation or place someone at risk of institutionalization. (For example, A3 ER Boarding, C2 MCO Oversight Failure (state's non-delegable duty), I3 Mismatch between Need & Available Services)
J2 Olmstead-Specific Violation Indicators	Data showing that a person is unnecessarily institutionalized **or** at serious risk, when: 1. Community placement is clinically appropriate,

	2. The individual does not oppose community living, and 3. Community supports can reasonably be provided. (For example, A1 Unnecessary Institutionalization, A2 Serious Risk of Institutionalization, B1 Authorized-but-Not-Delivered Services)
J3 Rehabilitation Act Section 504 – Federally Funded Provider Obligations	Interview references concern services delivered by any entity receiving federal funding, including: Hospitals Clinics MCOs with federal pass-through Medicaid dollars Providers contracted through Medicaid waivers Community mental health centers Long-term care facilities Use when: Barriers involve program access, reasonable modifications, or discrimination. The issue appears related to a specific provider's actions, not directly the state's structural decisions.
J4 Medicaid Act Entitlement Failures (EPSDT, Comparability, Reasonable Promptness)	Interview data indicates services required under Medicaid law are *not provided*, delayed, or substituted with institutional care. Use when: Waiver waitlists cause institutionalization (B3). MCO denies medically necessary services (B2). Cycling through EDs due to missing crisis services (A3).
J5 State Statutory/Regulatory Gaps (No Requirement Exists)	Interview shows that the underlying issue is due to a complete absence of statutory requirements, e.g.: No requirement for step-down facilities No regulation mandating minimum discharge planning protocols No mandated crisis response continuum No state-defined timeliness requirements for HCBS transitions Use when the problem is: Not illegal, because nothing requires the state to do it. A policy vacuum that generates predictable Olmstead exposure. (For example, C9 Continuum Gap, C4 Fragmentation)
J6 Enforcement Failure (ADA / 504 / Medicaid Act Not Enforced)	Evidence that the law technically applies but is: Not enforced Not monitored Not implemented in practice

	Delegated to MCOs without oversight Use with: State/MCO knowledge (G5) Contract enforcement gaps (C2b) Known alternatives not offered (I4)
J7 Absence of Reasonable Modification / Accommodation	Provider or system failed to modify rules, policies, or practices to avoid discrimination (a requirement under both ADA Title II and §504). Use when: Program rules are incompatible with disability (B11) Housing exclusions based on behavior without modification (B8) Transitions require accommodations not provided (B5 / D1)
J8 Civil Rights Violations by Non-state Actors (Contracted Providers)	Provider behavior creates disability discrimination, segregation, or access barriers, but the actor is not the state itself. Use when: Providers refuse or blacklist people (B6) Facilities exclude based on criminal history unrelated to clinical risk (B8) Hospitals discharge to homelessness despite known incapacity (B9)
J9 Lack of State Plan & Pace Obligations (Olmstead Planning Failures)	Iowa's plan/pace obligations are triggered when people remain institutionalized due to slow reform or missing services. Use when: Interview references insufficient resources but no plan to expand Long waits for community placement State aware of need but no timeline (G7)

Appendix B. Legal Argument

I. Legal Argument

The State of Iowa, acting through the Iowa Department of Health and Human Services (IDHHS), the Iowa Medicaid program, and the Iowa Mental Health and Disability Services Division, has violated and continues to violate the federal laws that are set forth below. The patterns documented above are not isolated failures attributable to individual provider decisions or resource constraints. They are systemic, foreseeable, and structurally caused by Iowa's failure to build and fund the community-based service infrastructure its federal legal obligations require. The following claims address each applicable legal basis and develop the legal significance of the factual record.

A. Title II of the Americans with Disabilities Act—Integration Mandate

Applicable Laws and Regulations: 42 U.S.C. § 12131(2), 12132; *see also* 28 C.F.R. § 35.130(d).

1. The Legal Standard

Title II of the ADA prohibits any "public entity" from discriminating against "a qualified individual with a disability" by reason of such disability in the "services, programs, or activities" it administers. 42 U.S.C. § 12132. Title II defines a "qualified individual with a disability" as an individual who meets the essential eligibility requirements for a service or program "with or without reasonable modifications to rules, policies, or practices." 42 U.S.C. § 12131(2). The Department of Justice's implementing regulation requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (the "integration mandate"). In other words, a lack of community-based services is a form of disability-based discrimination that violates Title II. *See, e.g.*, Townsend v. Quasim, 328 F.3d 511 (9th Cir. 2003) (holding that a state's denial of community-based long-term care to disabled persons it serves only in nursing homes may violate the ADA and 28 C.F.R. § 35.130(d) unless the state shows that providing community-based services would fundamentally alter its program). DOJ has explained that the "most integrated setting" is "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." Statement of the Dep't of Just. on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, Question 1 (June 22, 2011, updated Feb. 25, 2020), https://www.ada.gov/resources/olmstead-mandate-statement/ [hereinafter *DOJ Olmstead Statement*]. Segregated settings, in turn, often have institutional qualities, and include, but are not limited to, (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; and (3) settings that provide daytime activities primarily with other individuals with disabilities. *Id*.

In *Olmstead v. L.C.*, the Supreme Court held that unjustified institutional isolation of people with disabilities is itself discrimination based on disability. 527 U.S. 581, 597 (1999). The Court explained: placing people in institutions when they could be served in the community perpetuates unwarranted assumptions that they are incapable or unworthy of participating in community life, and confinement in an institution severely diminishes everyday life activities, including family relationships, social contacts, work opportunities, economic independence, and educational advancement. *Id*. at 600–01. Over institutionalization therefore isolates people from community life, and that isolation is the discrimination Title II prohibits. In the portion of the opinion joined by four Justices, the Court further concluded that the remedy for unnecessary institutionalization is community-based treatment, which states must provide when: (1) the state's treatment professionals determine that community placement is appropriate; (2) transfer is not opposed by the affected individual; and (3) placement can be reasonably accommodated, taking into account the resources available and the needs of others similarly situated. *Id*. at 607. Circuit courts have widely treated these three factors as controlling. *See, e.g., Waskul v. Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 463–64 (6th Cir. 2020) (reversing dismissal of an integration-mandate claim brought by individuals whose community living supports were reduced); *Davis v. Shah*, 821 F.3d 231, 264 (2nd Cir. 2016) (affirming summary judgment for Medicaid recipients on an integration-mandate claim based on risk of institutionalization).

The integration mandate is not limited to currently institutionalized individuals. *DOJ Olmstead Statement* confirms that "the ADA and the Olmstead decision extend to persons at serious risk of institutionalization or segregation

and are not limited to individuals currently in institutional or other segregated settings. *DOJ Olmstead Statement*, Question 6. Multiple circuits have adopted this interpretation. *See e.g. Waskul*, 979 F.3d at 460–61 ("[C]ourts have widely accepted that plaintiffs can state a claim for violation of the integration mandate by showing that they have been placed at serious risk of institutionalization or segregation."); *Davis*, 821 F.3d at 263 (holding that "a plaintiff may state a valid claim for disability discrimination by demonstrating that the defendant's actions pose a serious risk of institutionalization for disabled persons"); *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013); *Steimel v. Wernert*, 823 F.3d 902, 914 (7th Cir.[1]).[2]

2. Iowa as a Public Entity

The State of Iowa is a public entity within the meaning of 42 U.S.C. § 12131(1) and is therefore subject to Title II. Iowa administers its behavioral health services through IDHHS, Medicaid managed care organizations (MCOs), and, since July 1, 2025, a statewide Behavioral Health Service System operated by a contracted administrative services organization (BH-ASO). The state may not delegate supervision of its Medicaid plan and must enforce network adequacy standards for its MCOs. 42 C.F.R. §§ 431.10(e), 438.68(a). It cannot avoid Title II by delivering services through contractors. *See* 28 C.F.R. § 35.130(b)(1). The patterns of violation documented in this report reflect Iowa's systemic failure across all of these administrative arms.

3. Application to the Patterns of Violation

The patterns of violation identified above share a single underlying failure: Iowa has not built the community-based services that would allow people with severe mental illness to receive treatment in the most integrated setting appropriate to their needs. This section applies the legal standard to each pattern in turn and explains why each supports a claim under Title II.

ER Boarding / ED Cycling: Emergency treatment of an acute crisis is not itself the concern. The concern is prolonged boarding that continues after the emergent need has passed, when a person remains in the emergency department (hereinafter "ED") because no appropriate next setting is available. At that point, the stay no longer serves a treatment purpose and instead severs an individual from community support, family, employment, and social networks. This is precisely the kind of harm of institutionalization *Olmstead* identified. *See Olmstead*, 527 U.S. at 600–01. Prolonged boarding of this kind is itself unjustified segregation. Iowa's dependence on the ED also operates as a constructive denial of meaningful alternatives to institutional care: when the emergency department is the only available response to a psychiatric crisis, people are left at a "serious risk of institutionalization," and repeated ED cycling is evidence of that risk under the case law discussed above. Iowa's failure to provide an alternative to prolonged emergency department boarding constitutes ongoing discrimination in violation of 42 U.S.C. § 12132. DOJ should examine whether people with medical conditions of comparable seriousness who are awaiting a lower level of care are boarded in emergency departments for comparable periods. See Olmstead, 527 U.S. at 612 (Kennedy, J., concurring in the judgment). DOJ should also examine whether Iowa has any legitimate reason for a difference. If there is none, Iowa is in violation of Title II.

Jail Reliance for Clinical Needs: The same gap in community capacity that keeps people in emergency departments also keeps them in jail. Incarceration is the epitome of an institutional and segregated setting. When jail functions not as a consequence of genuine criminal conduct but as the only available setting providing medication, shelter, structure, and basic care to an individual with severe mental illness (SMI)—because no community alternative exists—it constitutes unjustified institutionalization under Title II. *Olmstead* holds that unnecessarily confining people with disabilities in segregated settings is discrimination because it isolates them from community life. 527 U.S. at 597, 600–01. A jail fits the Department of Justice's description of a segregated setting: a congregate setting marked by regimentation, limited privacy and autonomy, restrictions on visitors, and constraints on engaging freely in community activities. *See DOJ Olmstead Statement*, Question 1. A person held in jail only because Iowa has no community placement is isolated

[2] The Eighth Circuit, Iowa's federal appellate court, has not directly addressed whether the ADA's integration mandate extends to individuals at serious risk of institutionalization who are not currently institutionalized. The weight of persuasive authority supports the claim: seven circuits have recognized "at-risk" *Olmstead* standing, *see, e.g.*, *Waskul*, 979 F.3d at 460–61 (6th Cir.); *Davis*, 821 F.3d at 263 (2nd Cir.); *Pashby*, 709 F.3d at 322 (4th Cir.). The DOJ has consistently taken this position in Statements of Interest and enforcement actions for over two decades. *See e.g. Ball v. Kasich*, No. 2:16-cv-282 (S.D. Ohio 2016).

from comunity life for the same reason as a person held in a hospital, and it is Iowa's lack of placement capacity, not the person's own conduct, that keeps the person there. This claim is directed to detention that is not justified by the criminal charge itself—for example, detention prolonged beyond what the charge warrants because no treatment placement is available (see Part V.D)—and the Center asks the DOJ to determine how often that occurs. Detention that follows from criminal conduct is not unjustified merely because the person has a disability. The record here is notable: providers across disciplines describe incarceration as "a break," as the only extended observation period available, and as a de facto treatment plan. This reflects not individual provider decision-making but a structural system failure for which Iowa is responsible.

Continuum Gap / No Middle Tier: Both of those patterns trace to a missing tier of care. Title II's prohibition on unjustified institutional isolation is not satisfied when a state's system leaves qualified individuals with no realistic alternative to institutionalization, which is a constructive denial of meaningful alternatives to institutional care. The absence of a subacute or crisis residential tier is the structural condition that makes community living impossible for a significant class of individuals who could otherwise be served there. A binary system—institution or unsupported independence, with nothing in between—does not satisfy the integration mandate, 28 C.F.R. § 35.130(d), when the community-based alternative that treating professionals consider appropriate does not exist in functional form for the population that needs it. Iowa's administrative code nominally designates a "subacute" level of care, but a practitioner interviewed for this report stated that the code's definition is "clinically wrong" and that a 28- or 30-day program is not equivalent to sustained subacute treatment. A state that designates and pays for a level of care that providers cannot functionally deliver cannot treat the resulting institutionalization as an unavoidable cost of scarcity without showing that it is making reasonable progress toward community-based alternatives. See Olmstead, 527 U.S. at 605–06 (plurality opinion) (state asserting a fundamental-alteration defense must show a comprehensive, effectively working plan for placing qualified persons in less restrictive settings).

Exclusion and Placement Decisions That Are Not Individualized: Finally, the shortage of services is compounded by how the services that do exist are allocated. Providers described programs that exclude people because of co-occurring diagnoses (such as substance use disorder excluding people from mental health programs, and the reverse), acuity, behavioral presentation, or payer source, rather than because of an individualized assessment of the setting that would meet the person's needs. Under *Olmstead*, the assessment by the state's own treating professionals drives the analysis. 527 U.S. at 607. Justice Kennedy's concurrence would find discrimination where people with mental disabilities are denied the most integrated appropriate setting provided to "individuals suffering from medical problems of comparable seriousness." *Id*. at 612 (Kennedy, J., concurring in the judgment). The Center asks DOJ to determine whether Iowa and its MCOs make individualized placement determinations.

4. Olmstead Plan and Pace Obligations

Olmstead recognized, in Part III-B of the opinion, which four Justices joined, that states are not required to immediately create all community-based services, and that a state seeking to establish a fundamental-alteration defense should show that it has and is implementing "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings." 527 U.S. at 605–06. A qualifying plan includes "a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." *Id*. at 605.

Iowa has published an Olmstead Plan (most recently updated as the 2026–2031 Plan) and maintains an Olmstead Consumer Taskforce.[3] These are meaningful commitments. However, a plan that commits to community integration in the abstract while the documented patterns in this report persist—yearlong competency restoration waits, no functionally available subacute capacity, and a system in which incarceration and ED boarding are the only functional options—does not satisfy the *Olmstead* "effectively working" standard. The question is not whether Iowa has a plan; it is whether the plan is producing measurable progress for the population described in this report. The record here, derived from Iowa's own contracted providers, demonstrates it is not.

5. Prior DOJ Enforcement Actions

The DOJ has brought *Olmstead* enforcement actions against numerous states, resulting in consent decrees and settlement agreements. These are not binding precedent, and the Center does not cite them as such. They are offered as illustrations of the community services other states have agreed to develop to address patterns comparable to those

[3] Iowa Dep't of Health & Hum. Servs., Iowa Olmstead Plan 2026–2031 (Mar. 20, 2026), https://hhs.iowa.gov/media/18419/download?inline.

documented here, and of patterns the Department has previously treated as warranting investigation. The following are the most analogous:

United States v. Georgia, No. 10-CV-249 (N.D. Ga. 2010): The United States filed a complaint and negotiated a comprehensive settlement agreement requiring Georgia to expand its community services system (including crisis services, case management, and housing supports) for individuals with mental illness and developmental disabilities who were being unnecessarily institutionalized in state hospitals. The factual pattern—inadequate community capacity producing predictable hospitalizations—directly parallels the patterns documented in Iowa. The Georgia settlement required the state to develop mobile crisis teams, crisis stabilization units, peer support services, and supported housing, all within specific time frames and under independent monitoring. The record indicates that Iowa's equivalents to these components are either absent or not functionally available at the scale needed.

United States v. Delaware, No. 11-CV-591 (D. Del. 2011): The United States filed a complaint and simultaneous settlement agreement resolving its investigation into whether persons with mental illness in Delaware were being served in the most integrated settings appropriate to their needs. The agreement's stated goals were to "ensure that individuals in health crisis have sufficient community resources available to avoid unnecessarily being hospitalized or jailed"—language that maps precisely onto the patterns in this complaint. The Delaware settlement required crisis stabilization units, Assertive Community Treatment (ACT) teams, supportive housing, and peer support, along with independent monitoring and measurable targets. The record indicates that Iowa's comparable services are not functionally available at a similar scale.

United States v. New Hampshire, No. 12-CV-53 (D.N.H. 2013): A comprehensive settlement agreement requiring New Hampshire to significantly expand and enhance mental health service capacity in integrated community settings, including ACT crisis services, and supported employment. The settlement required deinstitutionalization based on each individual's needs, not on the availability of community resources—a standard Iowa's current system does not meet, since the unavailability of resources is precisely the mechanism producing institutionalization here.

United States v. North Carolina, No. 5:12-CV-557 (E.D.N.C. 2012): The complaint alleged that North Carolina violated the ADA by failing to provide community-based services that would allow individuals with mental illness to avoid unnecessary institutionalization. The complaint's focus on inadequate integrated housing options combined with crisis service gaps directly parallels the continuum gap patterns documented here.

The Iowa-specific record supplements these examples. On December 8, 2021, following an investigation under Title II and the Civil Rights of Institutionalized Persons Act, the Department issued findings that there was reasonable cause to believe that Iowa unnecessarily relied on State Resource Centers (the Glenwood and Woodward Resource Centers) to house people with intellectual and developmental disabilities instead of serving them in the community—demonstrating that DOJ has previously found reasonable cause to believe that Iowa's system fell short of integration mandate requirements for a different population (people with intellectual and developmental disabilities), and that the pattern of under-investment in community capacity is not new or unknown to the State.

B. Section 504 of the Rehabilitation Act

Applicable Law: 29 U.S.C. § 794.

1. The Legal Standard

Section 504 prohibits discrimination against individuals with disabilities in any program or activity receiving federal financial assistance. *See* 29 U.S.C. § 794(a) (prohibiting discrimination "solely by reason of" disability). Iowa receives substantial federal funding through Medicaid, SAMHSA Mental Health Services Block Grants, Community Mental Health Services Block Grants, and other sources, making its entire public behavioral health services system subject to Section 504. For the purposes of this report, the substantive standard for disability discrimination under Section 504 is coextensive with ADA Title II; a state that fails the ADA integration mandate also violates Section 504.

2. Independent Significance

Section 504 carries independent significance in two respects. First, it provides an independent federal enforcement pathway through the Department of Health and Human Services' Office for Civil Rights (HHS OCR), which investigates Section 504 complaints regardless of the DOJ's enforcement posture. Second, Section 504's causation standard—"solely by reason of her or his disability," 29 U.S.C. § 794(a)—has in some circuits been interpreted to require a showing of intentional discrimination for compensatory damages. By contrast, DOJ and HHS investigations and consent decrees do

not require compensatory damages as a predicate, making Section 504 a fully viable vehicle for the systemic injunctive relief sought here.

The patterns documented in this report constitute Section 504 violations in the following respects: Iowa's behavioral health service system denies individuals with SMI meaningful access to services by designing a system around requirements (appointment compliance, stable phone, permanent address) that the disability itself makes difficult to meet; subjects individuals with SMI to segregated settings (EDs, jails) not required for non-disabled individuals presenting equivalent crises; and fails to make reasonable modifications to its intake and service delivery requirements to accommodate the characteristics of the disability being served. *See* 42 U.S.C. § 12131(2) (Title II); 45 C.F.R. § 84.68(b)(7) (Section 504) (duty to make reasonable modifications). The comparison to non-disabled individuals presenting equivalent crises is subject for DOJ's investigation, and the Center asks DOJ to obtain data on how Iowa's system treats comparable medical and psychiatric presentations.

C. Related Medicaid Concerns

Applicable Laws and Regulations: 42 U.S.C. §§ 1396a(a)(8); 42 C.F.R. § 440.230(b)–(c).

Enforcement note: The Medicaid Act is enforced principally by the Centers for Medicare & Medicaid Services, not by DOJ. These concerns are included because the service denials and delays described below operated as a mechanism of the institutionalization described in Part V.A.

Iowa's Medicaid state plan must make medical assistance available to all eligible individuals with reasonable promptness. 42 U.S.C. § 1396a(a)(8). This obligation is not satisfied by enrolling individuals in Medicaid and then systematically failing to authorize or deliver medically necessary community-based services in a timely manner, thereby preventing crisis and institutionalization.

The qualitative data documents MCO denials of medically necessary services that bear no clinical justification — specifically, authorizations denied or reduced despite documented escalation of clinical need. One case documents an MCO repeatedly refusing to revise a level-of-care determination despite a client's accumulated history of suicide attempts, elopements, self-injury, and property destruction. The reasonable promptness obligation may be violated not only by delays in initial authorization but by the MCO's refusal to respond to changed clinical circumstances in a timely manner, leaving the individual in an inadequate, out-of-state placement. Iowa, as the supervising state Medicaid agency, bears responsibility for its MCO's failure to comply with the reasonable promptness requirement.

Each Medicaid service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). The documented pattern of service denials driven by behavioral profile and diagnostic classification violates that requirement. In particular, co-occurring substance use disorder (SUD) diagnoses are used to disqualify individuals from mental health programs and co-occurring mental health diagnoses are used to disqualify them from SUD programs. To the extent the services at issue are required services, the pattern also violates the prohibition on denying or reducing a service "solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c). Both violations arise because the system systematically denies services to the most clinically complex individuals, whose needs are comparably or more acute than those of people whose services are authorized. The Center also raises, as a factual matter for DOJ's inquiry and without asserting a separate claim, that people released from correctional settings without active Medicaid coverage or continuity of medication foreseeably cycle back into detention, which bears on the jail-reliance pattern described in Part V.A.3.

D. Due Process – Competency Restoration Detention

Constitutional and Legal Basis: U.S. Constitution. Amend. XIV, § 1; *Jackson v. Indiana*, 406 U.S. 715 (1972).

1. The Jackson Standard

In *Jackson v. Indiana*, the Supreme Court held that a defendant found incompetent to stand trial cannot be committed indefinitely solely on account of incompetency. 406 U.S. 715, 738 (1972). The Court held that such a defendant must either be released or committed pursuant to the general civil commitment standards—and that continued commitment must be predicated on a substantial probability that the defendant will attain competency in the foreseeable future. *Id*.

Jackson's core holding, that the nature and duration of commitment must bear some reasonable relation to the purpose the commitment is supposed to serve, has been applied to require timely access to restoration treatment. *See, e.g., Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1122 (9th Cir. 2003) (citing *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)) (holding that due process required the state to admit incapacitated criminal defendants to treatment within a reasonable

time, and affirming a seven-day limit). A defendant who has been found incompetent to stand trial and ordered into restoration treatment does not have an open-ended obligation to wait in a correctional facility while the state fails to provide the treatment the court ordered. *See Mink*, 322 F.3d at 1121–23.

2. Application to Iowa's Competency Restoration Pattern

The qualitative data describe defendants found incompetent to stand trial for minor offenses (breaking and entering, petty theft, etc.) who wait up to a year for placement at Iowa's forensic restoration facility, which holds approximately 28 forensic beds statewide. The Des Moines Register's investigative reporting corroborates times of up to a year at Iowa's two restoration facilities, during which defendants are held in county jails that are clinically unequipped to provide restoration treatment. William Morris, *Iowans found incompetent for trial wait in jail for treatment, their mental health ebbing*, Des Moines Reg. (Aug. 7, 2024), https://www.desmoinesregister.com/story/news/crime-and-courts/2024/08/07/in-iowa-being-found-incompetent-for-trial-can-mean-longer-county-jail-stay-mental-health/74060937007/.

This pattern raises compound constitutional concerns under *Jackson*. 406 U.S. at 738. First, the wait time itself may exceed what the constitutional relationship between commitment duration and restoration purpose permits, particularly for defendants charged with minor offenses carrying maximum sentences substantially less than the time spent awaiting restoration. Second, jail detention without restoration may worsen the condition that restoration is meant to address, as multiple interviewees noted, "sometimes when people stay in the hospital too long, they can become worse," a concern that applies with greater force to jails that are designed for security, not treatment. Third, the documented medication discontinuity (individuals discharged without prescriptions, returning to communities without follow-up) suggests that even when restoration is provided, the transition planning failures make relapse and reincarceration foreseeable. Courts have found due process violations where defendants found incompetent wait in jail for extended periods for restoration treatment. *See e.g., Mink*, 322 F.3d 1101 at 1121–23 (holding that keeping incapacitated defendants in county jails for weeks or months violated due process).

This claim does not depend on the integration mandate. The Center also asks DOJ to consider whether the conditions of detention for people in county jails awaiting competency restoration, and the delays themselves, warrant review under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 *et. seq.*, which reaches jails and state psychiatric facilities.

E. Cumulative and Structural Violation

1. The Claims are Mutually Reinforcing

The claims set forth above are legally distinct yet factually and structurally unified. Medicaid concerns (delayed and denied services) feed the ADA integration mandate violation (individuals cycle into EDs and jails because community services are unavailable). The ADA integration mandate violation is perpetuated by the *Olmstead* plan-and-pace failure (Iowa lacks a plan that produces measurable progress for this population). The due process violation (competency restoration delays) is caused in part by the continuum gap (which reduces the alternatives a court could order instead of incarceration). These are not independent problems amenable to independent solutions. They are manifestations of a structural failure because Iowa has not built the community-based behavioral health infrastructure its federal obligations require.

2. The State Has Notice of These Patterns

Notice is not an element of a Title II claim for injunctive relief, but it bears on questions that recur across the claims: whether the State can show an effective plan, whether its placement and funding decisions are justified, and, if damages were ever sought, whether the State acted with deliberate indifference. Iowa's notice is established by multiple, overlapping sources.

MCO Data: As the supervising state Medicaid agency, Iowa has access to utilization data showing patterns of ED boarding and jail cycling that are visible in Medicaid claims data.

***Olmstead* Plan:** Iowa's own 2026–2031 *Olmstead* Plan acknowledges the need to expand community-based mental health services, establishing state-level awareness of the gaps this report documents.

Prior DOJ Findings: The DOJ's December 2021 findings that there was reasonable cause to believe that Iowa unnecessarily relied on State Resource Centers for individuals with intellectual and developmental disabilities show that Iowa has previously been on notice of concerns about its reliance on institutional settings, although for a different population, and has not comprehensively resolved the underlying structural conditions.

Iowa's Last-in-the-Nation Bed Count: Iowa's documented status as 51st nationally for state psychiatric beds—2 per 100,000 against an expert-estimated optimal range of 40 to 60 per 100,000 (Silver & Hancq, 2024)—is publicly known, reported in Iowa media, and not disputed.

Notice matters because it undermines the contention that the state was unaware of the pattern or that the violations are attributable to the independent decisions of individual providers. The record here establishes that Iowa knows its system produces the outcomes that this report documents, and that the path to remedy lies in systemic investment.