Legislative Services Agency

# MINUTES

## Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Services Funding Study Committee

October 3, 2006

### MEMBERS PRESENT:

Senator Amanda Ragan, Co-chairperson
Senator James A. Seymour, Co-chairperson
Senator Joe Bolkcom
Senator Jack Hatch
Ms. Mary Nelson
Mr. Carl Smith
Representative Dave Heaton, Co-chairperson
Representative Danny Carroll
Representative Ro Foege
Representative Lisa Heddens
Representative Linda Upmeyer
Ms. Deb Schildroth
Mr. John Willey

# MEETING IN BRIEF

Organizational staffing provided by: John Pollak, Committee Services Administrator (515) 281-3818

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## I. Procedural Business.

**Call to Order.** Senator James Seymour called the initial meeting of the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury (MH/MR/DD/BI) Services Funding Interim Study Committee to order at 9:05 a.m., in Committee Room 102 of the Statehouse.

**Election of Co-chairpersons.** Senator Bolkcom moved that Senators Ragan and Seymour and Representative Heaton be made permanent Co-chairpersons of the Interim Committee. Representatives Foege and Upmeyer seconded the motion and the motion was approved on a unanimous voice vote.

**Adoption of Rules.** Mr. John Pollak, Legislative Services Agency (LSA) Legal Services Division, reviewed the proposed rules for the Interim Committee. It was noted that the legislation mandating the creation of the Committee provided for four public members, and that although these members would be ex officio, nonvoting members, they would be full participants in Committee discussion. Senator Bolkcom moved adoption of the rules as distributed, and Representative Upmeyer seconded the motion. The motion was approved on a voice vote.

**Recess and Adjournment.** The Committee recessed for lunch at 12:15 p.m., and reconvened at 1:00 p.m. The meeting was adjourned at 3:35 p.m.

**Next Meeting.** The next meeting of the Committee was scheduled for November 28, 2006, with a location to be announced at a later date.

## II. Service System History, Values, Goals, and Objectives.

**Overview.** A panel comprised of Mr. Pollak, Ms. Robyn Wilson, Department of Human Services (DHS), Ms. Linda Hinton, Iowa State Association of Counties (ISAC), and Mr. Bob Lincoln, Central Point of Coordination (CPC) administrator for Black Hawk, Butler, Cerro Gordo, Floyd, and Mitchell Counties, discussed the MH/MR/DD/BI Service System's history, values, goals, and objectives.

Mr. Pollak noted that the General Assembly struggles each legislative session with the issue of how much growth to allow in the system, and that counties are continually struggling with the potential of a crisis in the system due to extreme unforeseen increases in costs. The General Assembly determined that addressing the ongoing issues presented by the system necessitated the creation of an interim committee and enacted legislation to do so during the 2006 Legislative Session.

**Background.** Mr. Pollak provided background regarding the MH/MR/DD/BI Service System. He noted that the Committee's focus would be on the adult side of the system since this is the portion of the system for which counties have financial responsibility. He reviewed the various statutory provisions that describe the system and its objectives.

Mr. Pollak stated that the statute (Code section 225C.1) was originally enacted in 1981 and included a description of the system as complex, disparate, community-based, and a partnership between the state and counties. The objectives of the system were to retain the positive aspects while emphasizing consumer choice and supportive services. Although it has been amended since 1981, these themes remain in the statute.

**Recent Legislative Changes.** In 1993, 1994, and 1995, the General Assembly formed interim groups to review the MH/MR/DD/BI Service System. It was noted that until that point even though counties had a responsibility for funding services, they had little input in determining service delivery. Therefore, legislation enacted in 1994 included establishment of a single point of entry process, or the central points of coordination, to allow counties a process for input. The legislation also established county management plans. Mr. Pollak described the historical changes in the funding of the system, noting that S.F. 69, enacted in 1995, capped the services fund and eliminated the authority of counties to raise their supplemental levy for these expenses, with the thought that the state would cover all growth above the county limitations. One effect of this freeze, in addition to controlling growth in property taxes, was to lock any disparities in the system in place. However, Mr. Pollak also stated that there has been progress toward the goal of moving individuals to less restrictive settings.

**Member Questions.** In response to an inquiry from Co-chairperson Heaton regarding any lawsuits brought against the state for failure to provide appropriate services, the consensus of the group was that there had not been any such lawsuits. Mr. Kevin Concannon, Director, DHS, provided that in the Medical Assistance Program (Medicaid) portion of the system, services must be similarly operated in all counties. Co-chairperson Heaton asked that a representative of the Office of the Attorney General come before the Committee to discuss this issue at a future meeting. Ms. Hinton noted that as more services are offered through the Medicaid Program there is more consistency, but this also results in non-Medicaid services disappearing. Senator Hatch proposed that the Committee consider options to make the system more consistent and to have client need direct expansion of services rather than the services being linked to specific funding streams. Mr. Pollak added that access to providers varies across the state and that this adds to the disparity in the system. In response to an inquiry by Co-Chairperson Seymour regarding the role of legal settlement in individuals migrating to access services, Ms. Hinton noted that individuals do migrate and that they also come from outside of the state to access services. She noted that the county of residence cannot deny services and the county of legal settlement does fund services provided in the majority of cases. Additionally, she noted that legislation enacted in 2006 requires a determination of the costs associated with such migration.

**Detailed System Milestones.** Ms. Wilson provided an overview of the history of the county/state system with selected milestones. She stated that H.F. 2430, enacted in 1994, was the initial legislation regarding the system. This established the "base year" for expenditures, defined what was included in state payment to counties, established the county point of coordination (CPCs), and established the process for county management plans. However, the legislation that those involved in the system generally refer to is S.F. 69 enacted in 1995 which capped the services fund and deleted supplemental levy authority for MH/DD expenses. In 1996, S.F. 2030 provided that the "base year" chosen at the discretion of each county could be either the 1994 actual expenditures or the 1996 budgeted expenditures. As a result, the majority of counties selected the year with higher expenditures. In 1997, legislation defined the "allowed growth" distribution formula, changed the state/county management growth recommendation timeframe, and changed voluntary hospitalization procedures to be regulated by a single point of entry process. Legislation in 1998 established the "per capita expenditure target pool," the "incentive and efficiencies pool," distribution formulas, and the "risk pool," all used for distribution of growth moneys. Ms. Wilson

noted that these pools require counties to perform a balancing act. In 1999, legislation provided for county management plans to remain in effect, unless amended, rather than requiring annual submission; required submission of a strategic plan every three years for informational purposes only; and required annual reviews to be submitted to DHS for informational purposes only.

**Medicaid.** Ms. Wilson stated that in 2001 and thereafter, services funded through Medicaid have been added to the mix to reduce the funding crunch for counties. In 2001, the adult rehabilitation option (ARO) was added to the Medicaid state plan. This initially helped to provide savings to the counties, but ultimately, as greater numbers of individuals began receiving these services, the costs have increased. In 2003, Medicaid home and community-based services (HCBS) waivers were allowed to be provided in residential care facilities to alleviate county funding limitations and to offset changes in the State Supplementary Assistance Program formula. In 2004, adult day services, including day habilitation and pre-vocational services, were provided through HCBS waivers. In 2006, the State Payment Program was moved to counties for management.

Co-chairperson Heaton inquired about the effect of Medicaid involvement on increases in provider rates. Ms. Wilson responded that many counties noted that rates for providers of Medicaid services seemed to be more expensive than for services provided by counties. Ms. Wilson stated that her best guess regarding the reason for the increase in rates was due to increased paperwork.

**County Finances.** Ms. Hinton noted that the choice of base year by a county for the county's levy cap is critical to where counties are financially today. Ms. Hinton added that cuts in the allowed growth allocation for FY 2001-2002 by $18 million, an additional reduction in FY 2002-2003 of 2.6 percent, and the addition of Medicaid services have forced some counties to cut back on county-provided services.

**County System Values and Objectives.** Mr. Lincoln discussed the county system's values and objectives. He noted that from the beginning, the values established for the system have included empowering consumers, providing choice, and reducing the number of individuals in institutional settings. His perception of the role of county management includes three functions: providing access or a "storefront" to the consumer, coordinating services, and providing financial management of funding. The counties not only provide an access point for the MH/MR/DD/BI Service System, but also provide access to services such as veterans assistance, protective services, vocational/rehabilitation services, Social Security disability services, and others. The counties not only coordinate services on the MH/MR/DD/BI side, but also on the corrections side by providing diversion services. With regard to financial management, the counties utilize different methods in contracting for services and are also involved in regulation of provider rates.

**County Differences.** Although Mr. Lincoln's CPC office serves five counties, he noted that there is value in each county having a separate plan due to the difference in constituencies and differences in boards of supervisors. Mr. Lincoln compared Butler County, which is at the 20th percentile in service costs, to Cerro Gordo County, which is at the 80th percentile. He noted that availability of services is what makes for the disparity between the counties, but that even with the disparity Butler County does not feel underserved. He noted that there are differences between counties in the culture and the community and that having separate county systems allows for flexibility. He noted that services provided through Medicaid provide for a good "highway," but that counties still must provide other "roads." He provided the comparison of how Butler and Cerro

Gordo Counties addressed the issue of providing transportation. In Butler County, the county bought a car and hired someone to drive clients. In Cerro Gordo County, the county developed a more elaborate transportation system. Despite the disparity, both counties are meeting the transportation needs of their clients.

**Member Discussion.**

- **Regionalization.** Mr. Carl Smith asked Mr. Lincoln to offer his opinion on regional planning. Mr. Lincoln responded that a CPC plans regionally, but that he is a bit skeptical of regionalizing the system only to develop another layer of bureaucracy. He stated that what has been missing is the executive function, and that restoring the division in DHS should address much of the disparity in the system.
- **Supervisors.** Co-chairperson Heaton asked about the relationship of the CPCs with the boards of supervisors. Mr. Lincoln responded that it is a struggle to keep the board updated, but that there is usually at least one supervisor who is regularly involved while the remainder of the supervisors are only involved with the bigger issues. Mr. Lincoln reminded the Committee that the CPCs serve at the will of the boards of supervisors, and that the majority of the supervisors are engaged and are good advocates of the system.
- **Rural and Urban Differences.** Senator Bolkcom commented that the existing disparity between Butler and Cerro Gordo Counties might be just a culture of accepting that things are okay the way they are, but asked Mr. Lincoln to comment on where to go next. Mr. Lincoln noted that although needs are being met, any county, if asked, would welcome more resources. Ms. Hinton also commented that there are many nonpublicly funded services in the counties that are provided through churches and other charitable groups. Senator Bolkcom asked if the urban areas are subsidizing the rural areas in service delivery. Mr. Lincoln responded that many times in rural areas there is less demand. Ms. Wilson commented that although transportation is a huge issue, the other issue is that providers are just not located in rural areas. Mr. Lincoln noted that it is a critical mass issue, and that because of this small counties often share services in order to more efficiently deliver services. He noted that in Butler County there are six individuals in an intermediate care facility for persons with mental retardation (ICF/MR). In Floyd County, however, which is comparable in size, there are 18 individuals in the ICF/MR because one of the largest ICF/MRs is located in Floyd County. Ms. Mary Nelson inquired as to the role of the CPCs in recruiting providers. Mr. Lincoln noted that they regularly survey providers and consumers. In Butler County, where there was a lack of services, they converted the former DHS building into a resource center to provide a variety of services.
- **Provider Rates.** Co-chairperson Heaton asked about increases in provider rates. Mr. Lincoln noted that increases in provider rates might be due to the pent up demand from the earlier days of purchase of service. Co-chairperson Heaton noted his preference that any increases in rates go to pay direct costs.

## III. General Information Concerning the Persons Served and Services Provided.

**Overview.** A panel comprised of Ms. Jennifer Vermeer, DHS, Ms. Deb Schildroth, Story County CPC and Committee member, and Ms. Kerri Johannsen, LSA Fiscal Services Division, discussed the persons served and the services provided under the MH/MR/DD/BI Service System.

**Medicaid.** Ms. Vermeer discussed the Medicaid portion of the system. She noted that a person who is eligible for Medicaid through the MH/MR/DD/BI Service System receives all Medicaid benefits, including physician, inpatient, outpatient hospital, and prescription drugs. Medicaid also covers long-term care services for elderly and disabled populations. The services provided under Medicaid include both HCBS waiver services and institutional services. The waivers include the brain injury waiver, the ill and handicapped waiver, the waiver for persons with mental retardation, and ARO, which is being replaced with remedial services.

Institutional services are those provided in ICF/MR. Those requiring ICF/MR level of care may be persons with mental retardation or persons with a brain injury. The ICF/MR provides 24-hour institutional level of care and residents must have a need for and receive active treatment for their disability, medical needs, or behavioral needs. The services provided are geared toward helping the individual to live as independently as possible.

For FY 2005-2006, there were 2,167 individuals receiving Medicaid for ICF/MR level of care at a cost of $225 million in state, county, and federal funds. For FY 2005-2006, 7,701 individuals received services under the MR waiver at a cost of $218 million. This level of care requires that a person have mental retardation and require assistance with three activities of daily living. Services provided under the MR waiver include supported community living, personal care, habilitation, employment services, and respite. For FY 2005-2006, the brain injury waiver provided services to 524 individuals at a cost of $9 million. An individual must require ICF/MR or nursing facility level of care and require assistance with two activities of daily living. The Committee discussed the issue of homogeneous populations at ICF/MRs, and Co-chairperson Heaton expressed his support of establishing a distinct institutional level of care for persons with brain injury.

**Medicaid Managed Care — Mental Illness.** Relative to services for persons with mental illness, Ms. Vermeer noted that the Iowa Plan is the Medicaid managed care behavioral health plan contract for all mental health services. These services include inpatient psychiatric hospitalization, counseling and therapy, care management, and prior authorization. The contract does not cover pharmaceuticals, which are paid for on a fee-for-service basis by Iowa Medicaid Enterprise (IME). DHS Director Concannon provided that the cost of Iowa Plan services for FY 2005-2006 was $95 million. Mental health care is both institution-based, with services provided in the four mental health institutes or as inpatient services at county hospitals, and community-based, with services such as ARO. The ARO provides rehabilitative skills training and support for those with chronic mental illness with an expectation of skill development. This service is being transitioned into remedial services. Additionally, under the federal Deficit Reduction Act, habilitative or waiver-type services may be added to the Medicaid state plan. In FY 2005-2006, ARO provided services to 4,126 individuals at a cost of $36 million. As a side note, Ms. Vermeer noted that there is now a children's mental health waiver which allows children to receive HCBS waiver services and remain in their homes. The waiver serves 300 children at a cost of $1.2 million.

**Targeted Case Management.** Another Medicaid service provided to individuals in the MR/MH populations, and some individuals in the DD population, is targeted case management (TCM). This service is county-based and is a more intensive form of case management that helps to coordinate numerous services for individuals with many needs. In FY 2005-2006, TCM was provided to 11,000 individuals at a cost of $18.4 million. Case managers assist individuals with accessing services, receiving necessary services, coordinating services, and monitoring services in order to achieve treatment plan goals. The cost per person per month is $237.

**Waiver Utilization.** In response to a question by Senator Bolkcom regarding the increase in participation in the MR waiver, DHS Director Concannon noted that utilization of the waiver is expected to continue to increase because people are surviving and living longer than in the past. Ms. Schildroth noted that individuals are moving out of the state resource centers as providers develop community-based services. There is still a need for the resource centers, if that level of service is appropriate.

**County-Only Services.** Ms. Schildroth provided an overview of the county side of the system. Ms. Schildroth noted that even though system services are provided through the Medicaid Program, there is a variety of services provided through the counties that are not covered under the Medicaid Program. Counties respond to the service needs of their own communities, so services are not always the same from county to county. Ms. Schildroth described the example of children with autism. Many times the county is the first point of contact for a school. Even though the counties are not mandated to assist with children, they do help because early provision of services will stabilize the child and reduce the services needed in the future .

**Developmental Disabilities.** In response to member queries, Mr. Pollak noted that the category of developmental disability includes mental retardation, but that the existing legal mandates for coverage are only for the subset of mental retardation and not the broader category of developmental disability. Therefore, if a person has autism but does not also have mental retardation, county coverage of services for the individual is optional. Medicaid Director Eugene Gessow provided that ICF/MR level of care is to address mental retardation and related conditions. Therefore, the federal government does allow states to cover persons with developmental disabilities through the MR waiver, even though Iowa's MR waiver does not currently cover this population. Representative Heddens noted that many children with autism are covered under the ill and handicapped waiver.

**Client and Cost Information.** Ms. Johannsen provided information regarding Medicaid clients with county cost share by age and gender. The greatest number of clients are in the 18 — 29 age range. Approximately 58 percent of clients are female and 42 percent are male. For FY 2005-2006, there were 35,000 county Medicaid recipients, and of these 14,712 provided a copay with a total annual copay of $22,405,633.

Ms. Johannsen discussed the cost growth of various services relative to medical inflation. The HCBS waiver for brain injury has increased dramatically, which could be attributed to the high cost of just a few individuals. The growth in MR waiver costs covered as state cases has also dramatically increased, which may also be attributable to a small number of high-cost individuals. DHS Director Concannon noted that the increase at Woodward State Resource Center followed changes to implement the United States Department of Justice consent decree. Ms. Vermeer

noted that many reimbursements are cost-based. Ms. Schildroth provided that all waivers have monthly dollar caps as well.

In response to an inquiry by Senator Hatch regarding whether the need for services or the caps drive the services provided, Ms. Schildroth stated that a team recommends the services needed. Medicaid Director Gessow clarified that even though the team makes recommendations regarding services, the cap determines whether the service is available. A team may ask for an exception to the cap, but the role of the CPC is not to decide if an individual can receive services under a waiver. Medicaid Director Gessow also noted that in the last six months there has been a clarification that the caps are statewide caps, not per-county caps. Medicaid Director Gessow added that DHS is responsible for making sure that individuals know their rights to appeal, and that if the individual does not have the mental capacity to file an appeal that the individual is represented.

## IV. Rate Setting Process.

**Overview.** Ms. Julie Jetter, DHS, moderated the session on rate setting during which time Mr. Jeff Marston, DHS Medicaid staff, and Ms. Carol Logan, CPC Wapello County, provided information.

**Medicaid Rate Setting.** Mr. Marston provided information regarding rate setting for ARO, remedial service providers (RSP), and TCM. The basis of the payment is the actual, allowable cost per unit based on the submitted and approved cost report. The provider identifies and allocates costs directly attributable to each service and specifies the unit of service. Cost reports for these providers are due 90 days after the provider's fiscal year ends. The majority of the cost reports are due by September 30, annually. In reviewing the cost reports, the IME identifies areas of risk; reviews the reasonableness of the report compared with reported units to the Medicaid claims system units and the data warehouse; and determines, based on the federal Office of Management and Budget circular and Iowa administrative rules, which costs are allowable. Once allowable costs are determined, the rate is calculated for each procedure code based on the allowable cost divided by the allowable units. After the final rate determination at the close of the fiscal year, there is a settlement of claims. The settlement is performed using a mass adjustment which determines whether an overpayment or underpayment was made. The final rate becomes the new prospective interim rate until submission and review of the following year's cost reports.

ARO does not use a projected rate, but is based on an accrued cost report. There are instances in which there might be more than one open cost report, including instances in which there are changes in ownership. Medicaid Director Gessow noted that there are positives and negatives in a cost-based system. There is a balancing factor in ensuring that providers are neither underpaid nor overpaid. Medicaid Director Gessow also noted that once ARO shifts to RSP, rates may shift to a fee-based system. With ARO, there has been an adjustment each six months so there is less of a difference in the final adjustment. With RSP, there will be a cap on services.

**ICF/MR Rates.** The rate setting process for ICF/MR is a prospective, cost-related system with a per diem rate set for each facility. Cost reports are due on September 30 for the previous fiscal period (July 1 through June 30). The review of the cost report involves identifying areas of risk, and the Medicaid state plan and administrative rules define allowable costs and cost limits. Once the total allowable costs are determined, the per-patient day cost is determined by dividing the

allowable cost by the higher of actual census days or 80 percent of the total bed days. An incentive allowance is available to providers who have completed their second annual period of operation, and is paid to providers whose per-patient day costs decreased from the prior period or increased at a percentage less than that of the consumer price index for all urban consumers (CPI-U). The preliminary rate for existing ICF/MR providers is established for a facility by inflating the per-patient day costs by the CPI-U and adding any incentive allowance. There are limitations on the maximum allowable base rate. Base rates are rebased every four years to provide for the maximum allowable base rate calculation. Each year the base rate is inflated by the CPI-U to establish the maximum allowable base rate, and then the calculated rate is limited to that maximum allowable base rate. If a provider is above the maximum, the provider gets the maximum. If the provider is below the maximum, the provider receives that below-the-maximum rate. Mr. Marston noted that if a provider has high-cost clients, the provider may ask for an exception to the policy. Additionally, each provider is assessed 6 percent of the facility's total revenue for the preceding fiscal year. The assessment is reimbursed through a per diem add-on to the daily rate. Because this assessment is matchable under Medicaid, the state pays only a third of the cost and this is worth approximately $6 — 9 million to the state.

**HCBS Rates.** The rate setting process for HBCS waiver services varies based upon the type of waiver. For supported community living, there are "retrospectively limited prospective rates." New provider rates are based on projected costs, and existing providers may request projected rates if they have a change in consumers or when a consumer needs a change. Prospective rates are based on annual cost reports and the cost reports must include at least six months of actual data. Indirect costs are limited to 20 percent of direct costs. Units may be hourly or daily.

For supported employment, new provider rates are based on projected costs, prospective rates are determined annually based on annual cost reports with at least six months of actual data, and units are hourly only.

For respite, rates are agreed upon between the consumer, the interdisciplinary team, and the provider up to the maximums, and units are hourly.

For all types of HCBS rate setting, annual cost reports for the recently completed fiscal year are due September 30, with a reporting period of July 1 through June 30. A provider may receive a 30-day extension. The retroactive cost settlement is based on the annual cost report. Providers are required to repay any reimbursement that exceeds actual cost by more than 2.5 percent.

**County Rate Setting.** Ms. Logan discussed county rate setting and the County Rate Information System (CRIS), which is a rate setting methodology that enables counties to negotiate appropriate reimbursement rates with covered MH/DD providers and which provides technical support and training to member counties. Currently, 65 counties participate in CRIS. ISAC provides staff support and administrative services to the CRIS board. CRIS was established, when DHS purchase of service was eliminated, to help counties analyze costs and set rates. Ms. Logan noted that for providers it is often difficult because they have to fill out various cost reports instead of one uniform report. She also provided that counties have no influence on Medicaid provider rates, even though counties pay the nonfederal share of these services. With the new involvement of counties in state cases, she also stated that the State Payment Program has approved provider rates that the counties probably would not have paid if the counties had negotiated the rates.

Under CRIS, providers submit cost reports within 90 days of the end of the agency's fiscal year. The report is reviewed with the provider and the county is then able to negotiate with the provider. Ms. Logan stated that there is more opportunity with CRIS for negotiation, and that if there is a client with higher costs the county may agree to pay the higher rate.

In response to a question by Co-chairperson Heaton regarding why 34 counties do not participate in CRIS, Ms. Logan noted that there are some small counties with no providers and so they allow the host county to negotiate rates. Mr. Lincoln added that his counties do not participate because he feels that it is part of his role as a CPC to negotiate rates. Mr. Lincoln noted that although counties are not able to negotiate Medicaid provider rates, he feels that there is enough transparency in the system and added that rate setting is always more complex than merely cost.

Co-chairperson Heaton inquired as to how counties are able to ensure that payments aren't duplicated with providers, and Ms. Logan noted that having one cost report across payors would help to provide consistent health data. Ms. Nelson asked if it would be possible to obtain data regarding the extent to which rates are negotiated below the cost reports that are submitted, and staff responded that the data are probably available.

## V. Understanding the Property Tax Portion of System Financing.

**Overview.** Mr. Jay Syverson, ISAC, Ms. Sue Lerdal, LSA Fiscal Services Division, and Ms. Wilson discussed the property tax portion of the MH/MR/DD/BI Services System financing, covering six sets of materials.

**MH/MR Portion of Property Tax Funding.** Mr. Syverson referred to a handout which provided data regarding property taxes by authority (schools, county MH/MR fund, all other county funds, and cities) for FY 1996-1997, FY 2000-2001, and FY 2005-2006. Counties are limited by a levy cap to a maximum dollar amount for MH/MR/DD services. In FY 1996-1997, 6 percent of all property taxes, or approximately $99 million, was directed toward the county MH/MR fund. In FY 2005-2006, 3 percent of all property taxes, or approximately $113 million, was directed toward the county MH/MR fund. Mr. Syverson also reviewed a chart comparing the percent of property tax by authority for those years. In FY 2005-2006, the high percentage in county mental health funding was 6.7 percent and the low was 1.3 percent. Mr. Syverson also referred to a chart providing data on county fund levy rates for FY 1996-1997, FY 2000-2001, and FY 2005-2006. He noted that valuation is what drives property tax rates. The high rate in FY 2005-2006 was Wapello County with a rate of $2.67 per $1,000 of valuation, and the low rate was Dickinson County with a rate of $0.35 per $1,000 of valuation. Mr. Syverson noted that the tax rate in Dickinson County is much lower and this is due to valuation which is beyond the control of the budget setters. Mr. Syverson added that in FY 2006-2007, 64 counties are at their maximum levy rate, but that due to the need to keep their county MH/MR fund balances low counties raise and lower their levies.

**Fund Balances.** Mr. Syverson stated that one local source of funding for MH/MR services is property taxes, and another is the remaining county MH/MR fund balances. In FY 1999-2000, 75 counties representing 51 percent of the population had fund balances over 25 percent, while only three counties representing 2 percent of the population had fund balances below 10 percent. By FY 2004-2005, however, only 41 counties representing 23 percent of the population had fund balances over 25 percent, while 26 counties representing 42 percent of the population had fund

balances under 10 percent. Mr. Syverson stated that a fund balance of 25 percent is comfortable and a fund balance under 10 percent is not comfortable, but these counties might be able to receive additional state funds under the recent growth funding methodologies. In comparing all county fund balances, Mr. Syverson noted that in FY 2004-2005 nine counties had negative fund balances, but there is no real pattern to predict which counties will have certain percentage balances. He added that even though the dollars are locked in, people do move from county to county and services are needed. Additionally, when county populations decrease, valuations also decrease so that collections are not sufficient to cover the costs of services for those remaining.

**Allowed Growth.** Ms. Lerdal provided information regarding the MH/MR allowed growth history, including recommendations from the MH/MR/DD/BI Commission and the Governor, and the General Assembly's appropriations amounts. Because of the cap on levies since 1997 counties have spent down their fund balances, and state and federal funding has increased to fill the gap. The allowed growth formula percent is the result of multiplying the sum of the past base expenditure and the previous year's allowed growth by a factor or number. If a specific dollar amount is determined for the budget, the factor or number is determined by the formula in reverse.

**Distribution Methodology.** Mr. Syverson next referred to an allocation flowchart for FY 2006-2007 to explain allowed growth distribution to counties. The first state funding pool is the allowed growth pool and the amount in this pool is $12 million. All counties are eligible for funding from the allowed growth pool, and the allocation amounts change only minimally based on the latest general population estimates for each county. The second funding pool is the community services pool and for the past few years the amount in this pool has been $17.7 million. All counties are also eligible for funding from this pool. Allocations from this pool also change only slightly annually, and are based 50 percent on the latest general population estimates and 50 percent on the most recent poverty population data. The third state funding pool is the per capita funding pool and in the past several years all new money has been deposited in this pool. For FY 2006-2007 the amount in this pool is $32 million. Only counties that are levying at 100 percent of their maximum levy in the current year, have a fund balance below 25 percent for the prior two years, and have net county expenditures of less than $116.77 per capita in the year prior to being eligible are eligible for funding from this pool. If a county misses a filing deadline for either the annual financial report (December 1) or the County Management Information System (COMIS) report (December 1), the allocation initially reserved for a county is deposited into the three funding pools and is reallocated to eligible counties. The amount calculated based on the three funding pools is the initial allocation.

**Distribution Withholding.** The state allocation for the first three funding pools adds up to a certain amount, but the state only appropriates a portion of this amount to counties for mental health allowed growth. The amount that is the difference between the initial allocation and the final appropriation is the "withholding factor" and it is applied in a manner to provide additional funding to those counties that levy as much as possible and have low fund balances:

- The withholding factor is 100 percent for counties with an ending balance of 25 percent or greater and is graduated for counties with fund balances between 10 and 25 percent.

- If a county levies less than 70 percent of its maximum levy or levies more than 70 percent of its maximum levy but has a fund balance of 25 percent or more, the county does not receive an allocation.
- If a county levies greater than 70 percent of its maximum levy and has a fund balance that is less than 5 percent, the county receives its initial allocation plus a 3 percent inflation factor.
- If a county levies greater than 70 percent of its maximum levy and has a fund balance between 5 and 10 percent, the county receives its initial allocation plus a 2 percent inflation factor.
- If a county levies greater than 70 percent of its maximum levy and has a fund balance of less than 25 percent and greater than 10 percent, the county receives its initial allocation multiplied by a withholding factor.

The withholding factor is calculated by dividing the amount of the state appropriation that is left over after allocating funds to counties with ending balances of less than 10 percent by the combined initial allocation for all counties with ending balances of 10 to 25 percent. Each eligible county's initial allocation is then multiplied by the withholding factor to get the final allocation. In addition, there is another feature that only applies to counties with ending balances of 10 to 25 percent. This feature is called the "ledge" and provides that one of those counties can only "lose" an amount of money equal to the amount by which its fund balance exceeds 10 percent.

**Discussion.** Committee members, members of the panel, and audience members discussed how the complexity of the system makes it difficult for counties to plan and to make the right decisions.

## VI. Understanding the System Expenditures and Overall Financing.

**Overview.** A panel moderated by Mr. Pollak and comprised of Mr. Matt Haubrich, DHS, Mr. Jim Overland, DHS, Ms. Hinton, Ms. Lerdal, Medicaid Director Gessow, Mr. Lynn Ferrell, CPC Polk County, Ms. Jan Heikes, CPC Allamakee and Winneshiek Counties, Ms. Wilson, and Ms. Jetter discussed overall financing of the system. Mr. Haubrich noted that county controlled MH/MR/DD/BI funding is distributed from three pots: property taxes, property tax relief, and allowed growth. For FY 2004-2005, the total from these pots is $280 million. The total amount of county match funding for Medicaid services in FY 2004-2005 was over $123 million drawing a federal match of over $341 million. The total mental health Medicaid expenditures for FY 2004-2005, including county and state funding and state cases, was over $505 million, and includes MHI, ICF/MR, BI waiver, MR waiver, TCM, and ARO. This amount does not include Iowa Plan nonfederal expenditures of $43 million. When these revenue sources are combined with other state funding, client participation, and other federal support such as an estimated amount for federal Supplemental Security Income (SSI), funding for Iowa's mental health and disability services system for FY 2004-2005 was projected to be just over $1 billion. It was determined that a chart illustrating disability system funding does not include prescription drugs provided under the Medicaid Program, but does include psychotropic drugs paid for by the counties.

It was determined that there is an ongoing project to break down services by individual, but this is difficult to determine. The FY 2004-2005 data demonstrates that there were 45,206 individual county cases and another 2,931 state cases who received one or more services that year.

**Observations.** The panel provided a list of observations and perceptions concerning the information provided throughout the day. The Committee discussed observations and perceptions in general and with regard to Medicaid. Mr. Overland provided that the Medicaid waiver waiting lists are statewide. Ms. Hinton expressed concern that if cuts are needed the Medicaid services cannot be cut, so the 100 percent county services are the ones that will be cut. Ms. Wilson provided that if services are cut, they would only be reduced in number and not cut completely. Mr. Farrell noted that the Polk County Board of Supervisors will be reviewing its budget for FY 2007-2008 in two weeks and that the services that are 100 percent county funded and discretionary will need to be cut.

**Commission Comments and Questions.** Mr. Smith asked if information could be collected for the next meeting regarding what counties will be forced to eliminate services. Senator Hatch asked the Committee to review the letters and materials regarding elimination of services in Sac County and cautioned that services will probably need to be cut before the General Assembly has time to act in the 2007 Legislative Session. Representative Foege noted the issue of the need for provision of services to young adults with developmental disabilities who have severe acting-out issues and do not do well in group settings, which might necessitate reopening beds at the state resource centers.

Representative Carroll opined that the range in fund balances between counties does not seem to make sense. Ms. Wilson cautioned that looking at the county population does not provide the complete picture, which includes the severity of needs, the number of services, the number of providers — a whole conglomerate of needs and costs. Ms. Wilson noted that there might not be one good answer for the disparity. Representative Carroll reiterated the need for information that demonstrates who is receiving services and what services they are receiving. Mr. Haubrich noted that DHS has been trying to gather this data for over a year and that they hope to have the information by the 2007 Legislative Session.

Ms. Heikes stated that if you compare the counties of Winneshiek and Allamakee, for FY 2004-2005, Winneshiek has a fund balance of almost 75 percent and Allamakee has a fund balance of about 43 percent. In Winneshiek, there are no Medicaid waivers and the county decided to stop funding a nursing facility there. Therefore, all of the funding is county funding. They have the full array of services for a rural county and their fund balance is coming down. In Allamakee, they have implemented waivers and they are unsure of where to set their levy because they have one individual in Woodward State Resource Center and one in Clarinda Mental Health Institute that incur very high costs. The only place that they will be able to cut is in the sheltered workshop program. She also noted that although costs have increased with the provision of waiver services, it has also raised the bar of expectations and consumers are happier.

Mr. Smith asked that before the next meeting the reasons that certain counties are not participating in CRIS be determined. Ms. Hinton noted that participation in the CRIS Program has increased dramatically in a short time, and that, with increasing amounts of resources going toward Medicaid, CRIS addresses the county-only dollars. Ms. Schildroth noted that Story County has not joined

CRIS because they have had the same budgeting process for 20 years and they also include other types of services in their process.

Senator Bolkcom asked that the Committee review short-term issues as well as long-term issues relative to the system and that the Committee obtain more information about the counties that are in trouble now.

Co-chairperson Seymour noted that the first meeting provided a good start to the work of the Committee, and that he is not sure if the entire system needs to be eliminated and requires starting over with a clean slate or if the system merely needs to focus on the best parts and improve. Co-chairperson Heaton noted that it is important to continue to support the relationship between the state and the counties. He suggested that having one cost report might be an improvement to keep costs in line as needs continue to grow. Other members commented on their interest in the approaches described by Senator Bolkcom, Co-chairperson Seymour, and Co-chairperson Heaton.

## VII. Materials Distributed and on File With the Legislative Services Agency — Legal Services Division.

The following documents were distributed at or in connection with the meeting and may be accessed through the <Additional Information> link from the committee's Internet page at: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=155

- Committee Rules of Procedure.
- System Descriptions and Objectives in Statute and Previous Reform Recommendations — LSA Legal Services Division.
- System Milestones and Legislative History — DHS Staff.
- County Services Overview (from ISAC new officers manual).
- Inflation Information — LSA Fiscal Services Division.
- Current Medicaid clients with county cost share — by age category — DHS Bureau of Research and Statistics.
- Gender of Medicaid clients with county cost share — DHS Bureau of Research and Statistics.
- Medicaid utilization — Specific Program/Service clients FY 2001-2006 — DHS Bureau of Research and Statistics.
- Medicaid clients with county cost share — client co-pays — DHS Bureau of Research and Statistics.
- ISAC County Rate Information System (CRIS) — ISAC.
- Property Tax Portions by Levying Authority — ISAC.

- County Expenditures and Persons Served Per Capita FY1997-2005 — LSA Fiscal Services Division.
- County Fund Balances by Percentage of General Population — ISAC.
- Map of county fund balance percentages for FY 2005 — ISAC.
- Historical MH/DD Growth — Commission Recommendations/Governor's Rec/Actual — LSA Fiscal Services Division.
- Flowchart explanation of allowed growth distribution formulas — ISAC.
- Estimated Allowed Growth FY 2007 distribution — LSA Fiscal Services Division.
- DHS Service County Billings & County Expenditures for all Other Services — DHS.
- Federal share of Medicaid Dollars in County Disability Funding — DHS.
- Total Mental Health Medicaid Expenditures — DHS.
- Overall Disability System Funding — DHS.
- Overall System Funding by General Source — DHS.
- List of Observations About Overall System Expenditures — DHS, ISAC, and LSA.
- Provider Materials Regarding a Crisis in the Current Service System received by Co-chairperson Heaton.

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