Legislative Services Agency

# MINUTES

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

November 28, 2006

### MEMBERS PRESENT:

Senator Amanda Ragan, Co-chairperson
Senator James A. Seymour, Co-chairperson
Senator Joe Bolkcom
Senator Jack Hatch
Senator Maggie Tinsman
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

Minutes prepared by: Patty Funaro, Senior Legal Counsel, (515) 281-3040

## I. Procedural Business.

**Call to Order.** Co-chairperson Dave Heaton called the second and final meeting of the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury (MH/MR/DD/BI) Services Funding Study Committee to order at 9:42 a.m. in the Supreme Court chamber.

**Approval of Minutes.** Senator Joe Bolkcom moved that the minutes from the previous meeting on October 3, 2006, be approved. Representative Linda Upmeyer seconded the motion and the motion was approved on a unanimous voice vote.

**Recess and Adjournment.** The Committee recessed for lunch at 12:15 p.m. and reconvened at 1:18 p.m. The meeting was adjourned at 5:16 p.m.

## II. Financial Information Revision and Review of First Meeting Observations and Perceptions.

**Financial Information Revision.** Mr. Matt Haubrich, Department of Human Services (DHS), presented an updated chart on disability system funding which incorporates changes based upon inquiries from the first meeting of the Committee. The new chart includes Medicaid funding for Medicaid prescriptions which is a total of $96 million in state and federal funding.

Co-chairperson Heaton commented that the percentage increase from year to year is getting bigger. Mr. Haubrich responded that Medicaid is an entitlement so the increases are built in. Increases might be attributable to a number of factors including increases in the number served, increases in the number of services utilized, or increases in the number of high-cost services utilized.

In response to a question by Senator Bolkcom regarding what is included in the state cost figure, Mr. Haubrich stated that the figure includes the state share for Medicaid, state supplementary assistance, allowed growth, property tax relief, and the state payment program. Mr. Haubrich noted that the growth in the MH/DD system is not inconsistent with and not unexpected compared with the general growth in the health care system overall, which has been about 8-12 percent, annually.

**Observations and Perceptions.** Mr. John Pollak, Legislative Services Agency (LSA), Legal Services Division, reviewed the listing of observations and perceptions that was discussed at the first meeting. The listing was compiled from comments and discussion of DHS, county, and LSA staff concerning the data collected for the Committee's first meeting. The list included the following:

### A. Caveats and Assumptions.

- The chart regarding disability system funding may be misleading because until the new data system is implemented to improve the accuracy of the data, it is not possible to provide very accurate, unduplicated data.
- Data for the federal Supplemental Security Income Program, which is all federal funding, is not available, but the rough approximation is that 48,137 clients received services in FY 2004-2005.

## B. General Observations.

- There have been substantial increases in the amount of funding committed to Medicaid program expenditures in the system, in the number of individuals receiving Medicaid services, and in the number of Medicaid waiver services provided.
- Because county funding is capped and state funding has been controlled, the ability to expand services has mostly been through Medicaid due to the opportunity to leverage federal matching funding.
- There are three variables influencing cost: the number of individuals receiving services, the quantity of services being provided, and the amount of reimbursement.
- The reimbursement rates paid for Medicaid services have an effect on the rates paid for non-Medicaid services.

## C. Medicaid Observations.

- The expansion of Medicaid waiver services has not resulted in significant reduction in expenditures for institutional residential services or institutional beds.
- Generally, Medicaid does not provide all services needed by an individual; non-Medicaid services are also needed.
- Utilization of Medicaid services requires acceptance of federal requirements for the program.
- The entitlement nature of Medicaid means that once a person is eligible for and needs the services, the services and the financial commitment to the services continues. As long as county funding remains capped and the rate of state funding growth is controlled, funding currently committed to non-Medicaid services will have to be shifted to support Medicaid services.
- Although waiver slots may be temporarily limited by a waiting list, the waiver program slots are statewide and one county's excess slots will become available to the county with a waiting list.

## D. Perceptions.

- There is concern that the rise in demand for services will outstrip the ability to provide funding to meet the demand.
- It seems that the requirements for one or more of the funding sources changes annually which causes anxiety and difficulties. Some examples are: the change from the adult rehabilitation option (ARO) to remedial services; Iowa Vocational Rehabilitative Services (IVRS) is refusing supported employment funding to individuals eligible for Medicaid home and community-based (HCBS) waiver services, but the counties must pay the nonfederal share under the HCBS waiver whereas counties do not pay when services are provided through IVRS.
- Under the current funding structure, counties with strong valuation increases have a steadily declining portion of their property taxes dedicated to MH/DD services and the reverse is true for counties with stagnant valuation increases.

**Discussion.** Regarding the shift from payment for services through IVRS to Medicaid HCBS waiver services, Ms. Carol Logan, Central Point of Coordination (CPC) Wapello County, noted that Medicaid Gene Gessow is submitting a question to the Centers for Medicare and Medicaid Services to determine if IVRS could be the initial payor for services. Ms. Jennifer Vermeer, Assistant Medicaid Director, DHS, agreed to check on this issue. Ms. Linda Hinton, Iowa State Association of Counties (ISAC), noted that IVRS would not pay for services if the individual is eligible for HCBS waiver services, so the shift from IVRS to the Medicaid HCBS waiver is a 100 percent cost shift from the state to the counties. Then, once the individual begins actually receiving services through Medicaid, there is a cost shift to the counties to pay the nonfederal share.

Senator Tinsman noted that there seemed to be no other option than to cut other services in order to pay for the Medicaid services. Ms. Hinton stated that there is more stress on the system because counties may not have services they can easily cut. Counties are being forced to cut nonmandated services even though they want to continue to provide the services because they are less expensive than the mandated services. Co-chairperson Heaton asked that LSA, Fiscal Services Division, go through the list of concerns and attribute a cost to each issue.

In response to a concern voiced by Ms. Logan regarding the Medicaid waiver slots and the shift of state cases to the counties, Mr. Pollak noted that the state maintained financial responsibility for Medicaid waiver slots as a state responsibility when state cases were shifted to the counties.

## III. MH/MR/DD/BI Commission Adult Redesign Update.

### A. Overview of Redesign Report.

Mr. Carl Smith, Chairperson, MH/MR/DD/BI Commission and study Committee member, noted that a group of relatively new commission members reviewed the redesign report originally submitted on January 23, 2004, and developed a report. Mr. Smith noted that the review also briefly touched on the children's system. The system values include choice, empowerment of Iowans with disabilities, and supporting the rights, dignity, and ability of all individuals with disabilities to live, learn, work, and recreate in the communities of their choice. Some members have been frustrated with how slowly implementation of the original report has moved, but the original report did include an implementation assessment of six to eight years.

Recommendations for changes in the system include:

- Better access to services — funds should be available where the individual resides, not determined by legal settlement.
- There is a need for provision of a minimum set of core services that are available to eligible individuals no matter where they live. This does not assume the core services are available locally, but that there is equal access to services.
- Equalize funding and distribute funds equitably — counties contribute at an equalized property tax threshold and funds are distributed based on a functional assessment.

With regard to the children's system, the vision is for there to be a statewide system which is child focused, family driven, flexible, and coordinated with effective quality services and sufficient funding.

The challenges are to look beyond the past solutions, to understanding and defining meaningful outcomes, resolving disparities in required services, and not using potential cost as an excuse for inaction.

## B. Functional Assessment and Outcomes.

**Overview.** Dr. Michael Flaum, University of Iowa, Ms. Susan Koch-Seehase, Opportunity Homes in Decorah, and Ms. Jan Heikes, CPC Administrator for Allamakee and Winnesheik Counties, presented. They discussed the assessment tools selected and now being tested in various counties to improve the connecting of services to an individual, using an appropriation of $260,000 provided for fiscal year 2006-2007. There was also discussion of initiatives to identify outcomes and the importance of viewing quality from the consumer point of view. The efforts to implement evidence-based practices are intended to keep local control while applying standardization. The county plans for FY 2007-2008 will be required to address quality assurance provisions.

Dr. Flaum thanked Senator Tinsman and Representative Danny Carroll for moving the system forward during their tenure with the General Assembly. Dr. Flaum noted that the functional assessment initiative began as a means to inform case rates, but that a functional assessment provides much more including a way to look at what constitutes "necessary" services and "high quality." He remarked that there are many ways to look at service needs and quality and that one definition of necessary services from the consumer point of view is "a decent job, a place called home, and a date on Saturday night."

Dr. Flaum stated that Iowa needs a system that is capable of learning and that can be used to figure out what is being done right and wrong. The funding that was made available for the functional assessment is enough to get started. The bottom line is having a way to ask people how they are doing. If the system is to remain locally controlled, there is still a need for applying some standardization, core values, and an empirical basis for what is being done. The quandary is determining at what point standardization should be required. The group is close to getting to the implementation phase for outcomes for adults with mental illness.

**County Status.** Ms. Heikes noted that the functional assessment is a great tool to measure across counties and that about 36 counties are involved. The functional assessment is a good policymaking tool for persons with mental illness.

Ms. Koch-Seehase noted that the functional assessment is useful in case management and that more providers will embrace it to deliver necessary services as funding decreases.

**Variability.** Dr. Flaum noted that there is a lot of variability in the usage of an intermediate care facility for persons with mental retardation (ICF/MR) and that an ICF/MR is the right placement if the person needs to be there. He spent time at a 125-bed facility and used the functional assessment to assess residents. The good news is that most of the patients were in the right place, but there is a lot of variability. He also noted that at one facility, the bus to town used to stop one-half mile from the facility. However, since the bus route was changed to pick up people at the

facility, their use of the bus and quality of life has improved and they are integrating with the community.

**Assertive Community Treatment Program.** Co-chairperson Heaton asked about the Assertive Community Treatment (ACT) Program which is a treatment model for adults with severe mental illness. Iowa currently has five ACT teams serving less than 250 individuals. Dr. Flaum noted that only about 12 percent of individuals who need ACT statewide are able to access the program. ACT is an evidence-based program that really works to improve the quality of participants' lives. He is working with the Iowa Medicaid Enterprise and others to make the program more available without taking too big a toll on funding.

**ACT Program Discussion.** Co-chairperson Heaton suggested that there would be cost savings due to the preventive nature of the program. In response to a question by Representative Upmeyer regarding duplication of case management services relative to ACT participants, Dr. Flaum responded that ACT requires very intensive treatment and that participants would not be provided the duplicative, less intensive case management.

There was also discussion of access to providers who would be able to provide ACT services and other psychiatric care. Dr. Flaum noted that the General Assembly appropriated some funding to enhance the psychiatric workforce, but that the workforce shortage is at crisis levels. A study by the University of Iowa determined that there is an unfilled demand for 63 full-time and 20 part-time psychiatrists in Iowa. These are open positions that are funded and are seeking a provider.

Senator Tinsman suggested that local control in decisions about services seems to work better than mandating services and she used empowerment areas as an example of counties learning from other counties rather than the state mandating services. Dr. Flaum noted that Magellan made grant funding available for the ACT Program. The entity that saves the most in cost due to the program is hospitals and Medicare, but it is difficult to get Medicare to invest in programs, such as ACT, that avoid costs. Dr. Flaum also noted that another sticking point is the data infrastructure and the reluctance of the provider community to share information due to privacy and federal Health Insurance Portability and Accountability Act of 1996 compliance.

## C. Case Rates.

Mr. Haubrich discussed case rates. A case rate is a statistically determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functionality. For each subgroup, there is an assigned cell rate. Actuarial analysis can be used to determine case rates, but this requires a heavy need for data. Another means of determining case rates is by looking backward and continuing to do what has always been done. Alternatively, case rates can be determined in a prospective manner by using a standard basket of services. A county would then submit its case count for each cell rate, and funding would be allocated proportionately to the need of the county.

Mr. Haubrich noted there are four issues to address: investing in good data, finding ways to address financial risk, the frequency with which funding is distributed, and basing distribution on residency rather than legal settlement.

Co-chairperson Heaton asked how the process could be implemented so that a county could not "game" the system. Mr. Haubrich suggested using data system reviews and the functional assessment. Ms. Heikes noted that in the next county management plans to be submitted there is a requirement that the county develop a quality assurance tool.

Senator Tinsman noted that the example addresses another concept that has been proposed by the commission, establishing a county minimum-maximum levy range in place of the current frozen maximum dollar amount, and asked if the case rate proposal utilized the county minimum or maximum. Mr. Jim Overland, DHS, responded that the case rate proposal came from the fiscal workgroup and that it assumed the minimum in the calculations with the concept that counties could do more.

## D. Property Tax Levy Equalization Proposal.

**County Property Tax Levies.** Ms. Jane Halliburton, Story County Supervisor and MH/MR/DD/BI Commission vice chairperson, addressed the property tax provisions in the commission report. She emphasized the commission's goals in this area are to stabilize the system funding and provide a degree of flexibility. Priorities are to consolidate the funding streams into one fund, lift the county absolute dollar caps, and restore the state funding that was removed in FY 2001-2002. The commission is looking for an evidence-based approach that will allow flexibility but also some uniformity. She noted that while the focus has been on Medicaid services, there is a tremendous number of necessary services that are not provided through Medicaid. There is a need to strengthen the state/county partnership and work with those at the federal level.

The commission recommends folding the three state appropriations into one and removing the cap which is a dollar limit, not a levy limit. The current funding mechanism creates a rollercoaster effect. This, combined with the reduction in state funding in FY 2001-2002, has contributed to the crumbling of the base. This has resulted in counties coming forward with new plans that reduce services. With reference to the children's system, Ms. Halliburton noted that problems could be identified earlier to keep these individuals from moving into the adult system. The system needs to be stable and flexible and the best way to achieve this is to strengthen the county/state/federal partnership.

Co-chairperson Heaton noted that Henry County had received a grant for early intervention in the grade schools to assess children and refer them for services. Once the grant ran out, the school district was not able to continue the program, but another grant did become available. He recommended that the state, counties, and school districts get involved to provide grants for this early intervention. Mr. Smith noted that since the last meeting he was made aware that in Linn County the empowerment board is working to provide regional intervention for preschoolers.

**Discussion.** Ms. Halliburton emphasized the need to stabilize the current system. She stated that with the reductions in FY 2001-2002 that were never replaced and with the Medicaid changes, the system has become unstable.

Representative Carroll expressed his concern that if the current dollar cap is lifted, the equitability between counties would decrease and the system would go backward. He emphasized the need to focus the dollars and services on the individual. Representative Carroll expressed that a good

partnership has developed over the years between the state and the counties and that the system should move to a more state-funded, and less property tax-funded system, while maintaining local input. He suggested the possibility that the state could fund mandated services and the nonfederal portion of Medicaid and the counties could continue to fund the remainder of services. Ms. Halliburton noted that the majority of services are not Medicaid-funded services and that the focus needs to be on the entire system not just Medicaid.

Ms. Mary Nelson, DHS, asked if the commission recommendation of moving from a dollar cap to a levy range would increase or shift property taxes. Ms. Halliburton responded that the levy range would allow for more flexibility. Ms. Nelson asked what the feedback had been from county boards of supervisors regarding the move to a levy range. Ms. Halliburton responded that she had mostly heard about the concern regarding the shortage of funding reduction of services.

Mr. John Willey, Committee member, commented that counties want to provide services, but under the current limitations they are not able to generate the revenue needed.

Senator Jack Hatch suggested that for a quality system there needs to be statewide standards, and that if more state funding is needed, there has to be a local/state taxpayer partnership.

It was suggested that there is a belief that the state will not provide the funding needed for these services, so there is significant support among counties to lift the absolute dollar caps in order for sufficient funding to be provided.

## IV. Accountability Provisions.

**Medicaid.** Ms. Vermeer, Ms. Connie Fett, CPC for Cedar County, and Ms. Shelly Chandler, Iowa Association for Community Providers, all discussed the accountability and quality assurance approaches used in the current system. Each raised concerns about shortcomings in the current system, such as communication between Medicaid and the counties, disparities in the approaches used by the various counties, and multiple reporting requirements.

Ms. Vermeer discussed the principles, tools, and strategies utilized in maintaining Medicaid program integrity. She noted that Medicaid payments are made only if certain criteria are met: that the Iowa Medicaid program must operate in accordance with all applicable federal and state statutes, rules, guidance, and an approved state plan, and that all state Medicaid policies and procedures must meet certain criteria. DHS uses a number of tools and strategies to accomplish program integrity including rules, manuals, notices, training, a claims processing system and procedures, and both internal and external audits.

**Community Providers.** Ms. Chandler noted that providers deal with accountability on a daily basis from Medicaid requirements, to CPC requirements, to Department of Inspections and Appeals oversight for ICFs and residential care facilities (RCFs), to national accreditation entities. She noted that many times providers provide services in more than one county and each county has its own accountability system. Providers would like consistency and a single system of accountability. She noted that the process used in switching from ARO to remedial services was much appreciated by providers and allowed them to have input in the process. Ms. Chandler also suggested that cost reports be made consistent. She stated that when the County Rate Information System (CRIS) began, providers thought that the intent was to look at the actual costs

of services and to then sit down with the CPCs and negotiate a rate for the subsequent year. Instead, counties used the data to negotiate downward from what CRIS stated. She said that the rate should be based on the data and reality including the costs of insurance, gas, etc., and that the costs reported in CRIS should be used as a point to negotiate forward.

Representative Carroll emphasized the need for Medicaid and the counties to reduce duplication and to increase consistency in reporting. Senator Tinsman suggested that CPCs work to eliminate their inconsistencies in reporting.

**County Approach.** Ms. Fett noted that she and her providers have very open communication about provision of services and costs. In Cedar County, 63 percent of expenditures are for mandated services so there is very little room to be flexible. They have looked at areas that can be reduced and this would result in sheltered employment and transportation services being cut first. She has honest discussions with providers about what they really need, based on the CRIS report, and mindful that the funding pie is getting smaller. Ms. Chandler suggested that the cost of doing business is the cost of doing business, but that funding is limited. Mr. Willey noted that it is not only the counties, but all sources of funding that are creating the shortfall in the system. Ms. Fett emphasized that the majority of her providers are being fully funded based on CRIS and that it is critical to communicate with providers.

## V. Cost Reporting Consistency.

Ms. Debbie Johnson, DHS, discussed the report of the workgroup consisting of counties, providers, a provider accountant, and DHS that met several years ago to discuss the consolidation of cost reports for RCFs, ARO, ICF/MRs, and HCBS. The issues identified included: the services have different funding streams with different rules and policies for reporting and reimbursement of costs, there are many differences in the cost report schedules and instructions that would need to be addressed in rules, there are differences in definitions of allowable costs and cost limitations among the services, and county cost report forms vary. Some of the implications if cost reports are changed are that the calculation of provider reimbursements could be changed and would result in changes in reimbursement, either up or down, resulting in winners and losers. There was some discussion of the ability to report indirect costs vs. direct costs. Ms. Logan noted that there is the ability on the CRIS form to report indirect costs and direct costs.

## VI. Data Project Update.

Mr. Overland provided an update on the data infrastructure grant that has a goal of managing data from various data sets. Counties, Medicaid, the institutions, and the state payment program all have data about clients, and the goal of the grant is to create a data warehouse of this information. Fiscal year 2004-2005 data for all counties will be submitted December 1, 2006. The data will provide profiles of persons served, services, and providers.

## VII. Consumer and Advocate Perspectives.

Presentations were made by a panel of consumers and consumer advocates.

## A. Ms. Cherie Clark, Linn County Coordinator, Conner Center for Independent Living.

Ms. Clark participated in the meeting via telephone. She noted that there have been two recent initiatives by the General Assembly to improve service delivery to consumers with disabilities: IowaCare and restructuring. The IowaCare legislation in 2005 required a plan to enhance community options while reducing institutionalization. With regard to restructuring, she noted that community involvement is needed to improve the system, and that tweaking the system will not work but an overhaul is needed. With regard to improving the capacity of communities to support Iowans with disabilities living in their own homes, quality, consistency, and funding must be assured. Iowa has required accountability in the disability system, but for persons with disabilities, this just seems like red tape and paperwork which causes frustration and delay in accessing services. There is a need to counterbalance accountability with assuring that consumers achieve favorable outcomes. The enhancing community outcomes workgroup is part of the rebalancing initiative and includes a consumer satisfaction component. There are three issues critical to persons with disabilities: choice, control, and community. Choice means that the system must support people where they want to be; control means that services are consumer-directed and that a consumer selects services based upon individualized need; community means that the local area has the capacity to support consumers with the most significant disabilities.

The top items Ms. Clark suggested improving are: expand the cash and counseling funding to put the funds in the hands of the decision maker — the consumer; fully implement personal assistance services; fund the MH/MR/DD/BI system at the state level while maintaining local control and management and eliminating cost shifting; and eliminate legal settlement. She noted that stable funding is critical, including adequate allowable growth in the system. The Iowa system has been stagnant since the 1994 funding changes were was enacted and the system has not kept pace with national trends, such as funding personal assistance services.

## B. Mr. Rik Shannon, The Key Coalition.

Mr. Shannon described the coalition as a group of 20 statewide organizations that came together in 1995, in response to the 1994 changes in the service delivery system to improve Iowa's system of disability services. The top priorities of the coalition in 1997, and today, are to increase the equality of access to disability services and to implement a funding growth factor that adequately addresses new and underserved consumers. Moving toward equalizing services has never been accompanied by adequate funding, and today "equality" means a "rush to the bottom" as counties are being forced to eliminate services to nonmandated populations due to lack of funding. Nothing can be done to improve the system without providing additional resources. The system is in crisis and it is difficult to recommend short-term fixes only. Without increased funding or putting a mechanism in place to allow the counties to levy additional funds, there is little that can be done to maintain the system. If sufficient funding is provided to fully fund the system, efforts should be made to have money follow the person more closely. Tinkering with the current formula will no longer work, and changing who has responsibility for the system will not change the fact that more money is needed. It is either time to move forward or to admit that the state cannot move forward.

## C. Mr. Casey Westhoff, The ARC — Iowa.

Mr. Westhoff began by noting that he has two sisters with severe mental retardation. His recommendations for improving the system are: remove the county caps because the system is underfunded, consider making the statewide system less complex and putting consumers and their families back at the table, and reducing the red tape so that providers have more time to provide direct care as well as providing more training to providers.

## D. Ms. Sylvia Piper, Iowa Protection and Advocacy (P & A) Services, Inc.

Ms. Piper noted that her organization was established by the federal government to advocate for persons with disabilities. She provided a white paper regarding problems with the decision-making and appeals processes at the county level. She suggested that what the counties need to do in reducing or eliminating services and in providing an appeals process is to follow the law. The process used in terminating and reducing services and in providing notices of decision varies greatly from county to county. Even though the Iowa Administrative Code was changed to prohibit the use of county boards of supervisors as the body that decides appeals, many counties do not follow the rule and this presents a direct conflict of interest. Additionally, P & A has noted the crumbling of the system due to reductions in funding.

In response to a question by Co-chairperson Heaton regarding the conflict of interest situation in county decision making, Ms. Piper noted that P & A has been contacted by a number of consumers regarding elimination or reduction in services and that many counties are not following the law by utilizing the boards of supervisors in the decision-making and appeals processes. Ms. Deb Schildroth, CPC Story County, noted that many counties did change their county plans following the change in the rule, and that some of the information that is available online used in the P & A analysis is inaccurate and may need to be updated.

## E. Ms. Margaret Stout, National Association for the Mentally Ill — Iowa (NAMI-Iowa).

Ms. Stout noted that much progress has been made, but changes are needed. She recommended a list of her organization's top three changes: eliminating legal settlement, addressing the shortage of mental health professionals, and expanding the evidence-based programs such as the ACT program. If more funding is not provided in the next fiscal year and cuts are made, the cuts should be equitable and not focus on one disability group. If funding is increased, the state and counties should utilize a data system that is evidence-based in monitoring and evaluating the system to determine distribution of funds. She also suggested that multicounty contracts could be used to provide quality care and services in small counties. She applauded the MH/MR/DD/BI Commission for doing a wonderful job in coming up with a roadmap. She noted that mental health insurance is not addressing the need and that something must be done about mental health and substance abuse insurance coverage. She also suggested that there needs to be a dialogue regarding criminal justice and mental health among the agencies involved.

## F. Mr. Jack Holveck, DHS, Office of Consumer Affairs.

Mr. Holveck explained that his comments reflected his own observations and were not the views of DHS. He noted that people with mental illness are just like everyone else with the exception that they have been inexplicably struck by a hideous illness which they did not expect, had no

forewarning of, did not deserve, and which has detrimentally affected them. For many with mental illness, psychotropic drugs are the only antidote, but these drugs have many negative side effects and are very expensive. His top three recommendations for improving the system are: add funding so that the counties can provide services; require more uniformity of services across counties, and this should not be the lowest common denominator; and increase the number of mental health professionals in the state, with attention being placed on psychiatrists, not only other mental health professionals. He noted that the mental health funding system is very difficult to understand, and that, in his view, the 1994 funding changes with the cap limitations have hurt many people by not providing adequate funding. He suggested that a first step be providing adequate funding and that if this does not work, the system move in another direction. He questioned whether the system will ever be adequately funded and provide uniformity of services if it is dependent on property taxes and suggested moving to a state-funded system with local administration.

### G. Committee Discussion.

The Committee discussed the shortage of mental health professionals and the difference between programs developed to decrease shortages in other professions and the residency program required for psychiatrists.

## VIII. Provider Perspectives.

### A. Ms. Shannon Strickler, Iowa Hospital Association (IHA).

**Overview.** Ms. Strickler noted that IHA convened a mental health task force in 2005 to identify challenges that hospitals have operating in the existing system and proposed changes. The Committee was provided a copy of the white paper produced by that task force. The workgroup had a provider/hospital focus, so many of the solutions addressed access and patient care issues rather than the funding of the system. Many of the changes made during the 2006 Legislative Session were supported by IHA and IHA considers them the most significant changes made to the system in more than a decade.

**Shortage of Professionals.** The changes made, however, were just initial steps in repairing a fragmented system. One outstanding issue is access to mental health professionals and services. Three-fourths of Iowa counties are in mental health professional shortage areas. This forces care to be provided on the "back end" in hospital emergency rooms and inpatient care. Iowa has nearly the least number of psychiatrists per resident of any other state, many psychiatrists will no longer treat patients in inpatient hospital units, and child psychiatrists in particular are in extreme shortage. When a mental health patient leaves an inpatient setting, follow-up is recommended within two weeks of discharge; due to the shortage of professionals in Iowa, the wait time is two months. Thirty-five percent of Iowa's mental health professionals are age 55 and older, and psychologists and other behavioral health care providers are at the highest risk of having a shortage of all licensed health professionals. Adequate reimbursement is paramount to recruiting and retaining psychiatrists and other behavioral health care professionals. The 2006 increase in Medicaid reimbursement was a strong first step. Iowa also should provide additional funds to broaden the use of telemedicine and alleviate the pressure of worker shortages.

There is a need for more available preventive, proactive, outpatient care because it is better medicine and because it provides savings to the state and counties. Community hospitals have played an even greater role in providing inpatient care over the years and must be adequately funded.

**Cost-Based Reimbursement.** The change to cost-based reimbursement for Medicaid mental health inpatient hospitalization was a strategic method to help retain the amount of services available in the state. The bed reductions and waiting lists at the mental health institutes (MHIs) have put a strain on hospitals and community residential providers looking for long-term acute care stay placements. Care must be appropriate, and a continuum of care options must be available.

**Subacute Care.** In Iowa the missing level of care is subacute care for those needing psychiatric services, which is the level of care between inpatient acute psychiatric care and community residential care. The existing MHIs have the physical capacity and necessary services to accommodate this level of care. An alternative would be to expand community residential capacity only in the case where the facility has proper support and resources in place. Legal settlement should be entirely eliminated with the move toward residency. Substance abuse is an interconnected issue with mental illness and the state needs to look at how these two systems interact and implement changes to make them more cohesive.

Co-chairperson Heaton noted that there are two issues that must be addressed: how to provide care in nursing homes to violent individuals and, for those with dementia, the challenge of providing care to those who become violent.

## B. Targeted Case Management: Mr. Dan Vonnahme, ISAC, and Ms. Diane Diamond, DHS.

Mr. Vonnahme and Ms. Diamond provided information regarding targeted case management. Targeted case management is a Medicaid service to manage multiple resources effectively for the benefit of Medicaid consumers. The system helps consumers gain access to appropriate and necessary medical services and interrelated social and educational services. Necessary evaluations are conducted; service and treatment plans are developed, implemented, and monitored, and reassessment of consumer needs and services occurs on an ongoing basis. Each of the 99 counties selects their targeted case management provider. Mr. Vonnahme noted that their recommendation of what to change is "stop changing everything." They suggested continuing with local operation of the system because the consumer knows the local team.

## C. Ms. Shelly Chandler, Iowa Association of Community Providers.

**Overview.** Ms. Chandler noted that within the current county system there is great confusion regarding the appeals process and that, because the system is locally controlled, there are great inconsistencies and a lack of general oversight.

**System Principles.** She presented a document listing principles for Iowa's mental health system developed by the association's board. The principles include: that individual and family strengths,

needs, choices, and preferences are the basis for the development of services and systems, planning, and delivery of services; equitable access, funding, and care for all no matter where they live in the state; address the potential for conflict of interest among funders, providers, and those who utilize services; oversight authority is needed to ensure accountability and standardization of systems and processes; the system should promote development of evidence-based services and best practices; and there should be fair and consistent reporting requirements for rate setting and cost reporting implemented consistently throughout the state. The providers find that the rules for the program are sometimes vague, but do appreciate having input in the development of the rules. Ms. Chandler noted the association's support for the appropriation of funds for brain injury during the 2006 Legislative Session. She noted that while very few providers have adequate training to provide services to persons with brain injury, the association will be providing more opportunities for such training.

Senator Tinsman commented that having both local control and statewide total consistency is impossible, and that if local control is more important the system will have to allow for differences.

## IX. 2008 and 2009 Growth Recommendations.

**Overview.** Mr. Smith provided comments from the perspective of the MH/MR/DD/BI Commission. The commission makes a recommendation regarding allowed growth by April 15th, annually. The commission has been hearing from counties that unless more funding is provided, optional services will be reduced.

**ARO Change.** Co-chairperson Heaton asked how the changes in ARO will impact funding. Ms. Vermeer commented that DHS had worked with counties in defining services in order to make the best match for recipients of services and to minimize the impact on counties, but that the magnitude of the impact is still unknown. Mr. Smith noted that there were some offsets to county budgets in providing additional Medicaid-funded services, but that counties also offer a large amount of other non-Medicaid services and funding problems have developed in this area.

**Commission Recommendation.** Mr. Smith and Ms. Sue Lerdal, LSA, Fiscal Services Division, discussed the status of the commission's recommendation for allowed growth for FY 2007-2008 and FY 2008-2009. The commission did not complete its recommendation for FY 2008-2009, but discussed the need to revisit the growth amount enacted for FY 2007-2008 to restore the amount of the reduction applied in FY 2001-2002. Ms. Lerdal supplied a calculation of inflation on the original reduction amount resulting in a figure of $20.4 million to restore the reduction. In addition, late in the 2006 legislative process, $3.1 million was added for FY 2006-2007 that was previously suggested should be included for FY 2007-2008. It was noted that another $2.1 million was added for counties to assume responsibility for state cases in FY 2006-2007.

**Effect of Medicaid.** Senator Tinsman noted that when Medicaid services were expanded, this relieved some of the financial costs to the counties. Ms. Schildroth noted that initially this was the case, but that after Medicaid services were expanded, provider rates were also increased by as much as 40-50 percent over a two-year period. Additionally, when ARO was put into place, consumers were shifted to ARO and this became an additional county expense. Ms. Logan noted that counties are not authorized to have any control over Medicaid.

**Fund Balances.** Representative Carroll noted that the formula is based on good logic, but that the system provides a perverse incentive for counties and CPCs to get a fund balance down below 5 percent and to focus on the fund balance rather than the needs of consumers. He suggested that allowed growth funds be targeted at individual consumers rather than at counties.

## X. County Fund Balance Difficulties.

### A. Small County Difficulties.

Mr. Todd Rickert, CPC Tama and Grundy Counties, and Ms. Lonnie Maguire, CPC Harrison, Monona, and Shelby Counties, presented the perspective of small counties. Mr. Rickert noted that his CPC is anticipating that there may be funding difficulties in Grundy County, and that having even a few high expense clients can be devastating to the budget. The dilemma is providing necessary services while balancing the budget. The CPC tries to work with advocates, families, providers, and case managers to meet consumer's needs. They are looking at voluntary reductions first, such as eliminating services if they are not being used, or just reducing services. They are also looking at retirements, staff reductions, and moving people to less restrictive environments if the right kinds of support are available.

Ms. Maguire noted that the counties she represents are not having financial difficulties presently, but that Shelby County had difficulties in 2002. At that time the fund balance was less than 5 percent and they worked with families, consumers, providers, and others to do the least amount of damage. All of the voluntary providers took reductions in reimbursements that were 100 percent county funded. Case managers took voluntary reductions in 2003.

### B. Large County Difficulties.

**County Situation Changes.** Mr. Lynn Ferrell, CPC Administrator Polk County and MH/MR/DD/BI Commission member, discussed county fund balance problems and the various Medicaid provisions that allowed counties to maintain services within the tight funding experienced in the last several years. He noted that if a 12 percent cost increase is expected for Medicaid, a 6 percent increase for county MH/MR/DD/BI services will result, since Medicaid is half of the expenditures, but allowed growth has rarely been increased by more than 2 percent per year.

Mr. Ferrell presented a document that analyzes factors driving the costs of the system, the allowed growth amount, and the means of covering the gap between the need and the funds available (the "rabbit" used to cover the gap). He stated that each time that allowed growth has not increased at the rate necessary to cover normal costs, there has been some "rabbit" to pull out of the hat for counties to get by. However, he stated that at this point there do not seem to be any more rabbits. He also reviewed and compared county fund balances for FY 2000-2001 and FY 2004-2005 and county levies for FY 2000-2001 and FY 2006-2007. He noted in FY 2006-2007 that 73 percent of the state population lives in counties which levy at the maximum. In FY 2004-2005, 42 percent of the state's population lived in counties with fund balances less than 10 percent, compared with 24 percent in FY 2000-2001.

**Polk County Situation.** With regard to Polk County, the county completed its budget before knowing how much funding they will have for the MH/DD system. Polk County has seen an explosion of new consumers. With the expansion of Medicaid services beginning in FY 2002-2003, provider rates were increased and even though the increases were well-deserved, it must be recognized that the counties are paying the nonfederal share. Currently there is a waiting list of 80 to 90 consumers. In FY 2006-2007, the county is eliminating all prevention, public awareness, consultation and education programs, and for FY 2007-2008, the county is planning to eliminate all discretionary programs and eliminate services with the exception of inpatient and outpatient services to all discretionary populations.

Mr. Ferrell noted that in comparing counties, the problems are proportional. He used Linn County as an example and said that if Linn County, which is about one-half the size of Polk County, is compared with Polk County, the problem in Linn County is about one-half the size of the problem in Polk County. He noted that approximately $1 million in additional funds is needed each year to serve new consumers in Polk County, and that for FY 2007-2008, Polk County predicts a $4.9 million shortfall. He noted that while expanding Medicaid services has brought the counties through in years where growth funding was not provided, the question now is what amount is needed to make the counties whole.

Mr. Ferrell supports changing to a freeze on levy rates rather than keeping the current cap on dollars.

## XI. Review of Issues and Options.

**Management Plans.** Mr. Smith noted that in the county management plans to be submitted after July 1, 2007, there is an expectation of measuring results. He noted that there is still much work to do on the data management system. There is a desire for the commission to do more with county management plans, but also to use them to provide information.

**Senator Tinsman's Comments.** Senator Tinsman stated that this might be her last meeting and that she wanted to offer her continued assistance based on her almost 30 years of experience regarding the issue. She offered her suggestion that the system be an equal partnership between the counties and the state, with the state contributing more funding. There is a need to "unfreeze" the levy or to freeze the levy based on rates to allow more flexibility. She noted that if property taxes are involved, more people will pay attention to the system than if the state takes over the entire funding system. She compared this system with the court system and noted that when the state took over the court system from the counties, the counties were relieved but that costs zoomed up. She also noted that on an individual consumer level, a sliding fee scale might be a positive step. Consumers want certain services and are willing to pay their share, because it gives individuals a sense of dignity and a sense that they are getting better services. She supports the idea of uniform "guidelines" for services for each region of the state, not total dictation by the state.

Co-chairperson Heaton thanked Senator Tinsman and Representative Carroll for their leadership in the area of human services, and noted that they will be sorely missed, but that he hopes that they continue to advocate for their positions, especially in the area of the mental health system.

**Proposals and Suggestions.** Co-chairperson Heaton asked LSA staff to compile the suggestions and recommendations made for the Committee's review.

## XII. Materials Filed 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

1. Overall Disability System Funding — Update from DHS.
2. Previously distributed observations and perceptions from October 3 Meeting.
3. MH/MR/DD/BI Commission System Redesign Report — 2006 Update.
4. Commission Recommendations PowerPoint Slides.
5. DHS Description of Medicaid Program Accountability — Integrity Provisions.
6. DHS Discussion of Consolidating Cost Reports.
7. DHS Description of How Case Rates Might Work.
8. DHS Profile of persons served by the states mental health system — various tables.
9. National Alliance for the Mentally Ill — Iowa Memorandum from Margaret Stout.
10. Iowa Protection & Advocacy Services, Inc. White Paper.
11. Iowa Association of Community Providers — Principles for System.
12. Iowa Hospital Association Issue Review of Behavioral Health Care Access for Iowans.
13. Growth Distribution Formula Flowchart and Recap of Commission Growth Recommendation as of 11/16/2006.
14. Mental Health Statistics -- DHS Report to Federal Government.

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