MINUTES

Mental Health and Disability Services Redesign Fiscal Viability Study Committee

December 18, 2012

MEMBERS PRESENT:

Senator Joe Bolkcom, Co-chairperson
Senator Jack Hatch
Senator David Johnson
Senator Amanda Ragan
Senator-elect Mark Segebart

Representative Renee Schulte, Co-chairperson
Representative David Heaton
Representative Lisa Heddens
Representative Linda Miller
Representative Mark Smith

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 and Adjournment. The first meeting of the Mental Health and Disability Services Redesign Fiscal Viability Study Committee was called to order by temporary Co-chairperson Bolkcom at 10:04 a.m., Tuesday, December 18, 2012, in Room 103 of the State Capitol, Des Moines. In addition to committee members, Senator Robert Bacon and Senator Nancy Boettger attended the meeting. The meeting was adjourned at 3:56 p.m.

Election of Permanent Co-chairpersons. Members of the committee unanimously elected temporary co-chairpersons Senator Bolkcom and Representative Schulte as permanent co-chairpersons.

Adoption of Rules. Members of the committee adopted procedural rules which are available from the Legislative Services Agency.

Opening Comments. Co-chairperson Bolkcom reflected that the need for mental health services could not be greater in the state. The goal of the redesign is to have the best mental health services available by maintaining services while also requiring the General Assembly to consider new resources. Co-chairperson Schulte thanked all those who have been involved in the workgroups to date and encouraged everyone to move forward together in a positive direction.

II. Children's Disability Services Workgroup Report

Co-chairpersons of the Children's Disability Services Workgroup, Dr. Mark Peltan, PhD, clinical psychologist, and Ms. Jennifer Vermeer, Medicaid Director, Department of Human Services (DHS), reviewed the workgroup's report. They provided an overview of the background of the workgroup which has met for two years. The recommendations from the 2011 workgroup included instituting a system of care framework for children's services in Iowa; developing and rolling out a set of core services across the state; allowing more flexibility in the psychiatric medical institution for children (PMIC) services; using a health home model of service delivery; and creating a strategy for bringing children back from out-of-state placements.

The children's mental health system in Iowa has been fragmented and has not been integrated and coordinated with all of the aspects of the service network including education, child welfare, juvenile court services, primary health care, substance-related disorders, and other services. The state has been working in recent years to develop a community-based system of care for children, with a number of examples being implemented through grassroots efforts such as the Community Circle of Care in northeast Iowa, the Central Iowa System of Care in Polk and Warren counties, Four Oaks in Linn and Cerro Gordo counties, and Project LAUNCH in Des Moines.

2012 Recommendations. The charge for the 2012 workgroup was to develop an implementation strategy for a statewide, publicly funded, integrated service system for children and families to ensure that children with mental health needs and intellectual and developmental disabilities receive essential services. The 2012 workgroup performed a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the current children's mental health system, and made the following recommendations to fulfill the vision of the workgroup that all children in Iowa have access to an integrated system of coordinated services and supports that they need in their communities to successfully reach their optimal potential:

1. That a statewide comprehensive system of care be accessible to all Iowans.
2. In order to fully plan and execute a comprehensive and inclusive mental health and disability system for children and youth, create, through legislation, a state level Iowa Children's Cabinet, led by DHS, to promote optimal, holistic well-being to all children in the state. The recommendation includes the responsibilities of the cabinet, the governance structure, membership, and leadership.
3. Phased-in implementation of the children's system should begin with establishing health homes to provide care coordination, case management, family navigation, and family and peer support and other services. The initial focus will be on Medicaid-eligible children with a serious emotional disturbance (SED) and such children with SED and a co-occurring disability, but the goal is to build the system to include all children, particularly those with intellectual disabilities, developmental disabilities, special health care needs, and other related challenges. The initial Medicaid health home for children with SED should be ready for implementation in the spring of 2013.
4. Evaluation of the system should be performed by DHS. Data collected will be used to determine the pace and scope of evolution of the comprehensive system of care for children. The evaluation will address process, structure, and child and family outcomes.

Mr. Peltan noted that one improvement has been linking Magellan Behavioral Care of Iowa with the systems of care and PMIC workgroup to find placements for children who might otherwise have been placed out of state. This effort to date has resulted in placing 28 children in state who might otherwise have been placed out of state.

Ms. Vermeer noted that the Children's Cabinet is an effort to provide for coordination of the system through buy-in at the agency level. This is a pragmatic approach to provide a point of accountability in the state system that develops, oversees, and evaluates the system as it develops over time. She also noted that the report references to "juvenile justice providers" should be the broader "state court system."

Discussion:

Accountable Care Act. In response to a question by Senator Hatch, Ms. Vermeer noted that the development of the children's system is consistent with provisions in the federal Affordable Care Act such as Accountable Care Organizations (ACOs). She said that the state innovation grant application that the department submitted to the Centers for Medicare and Medicaid Services to establish a multipayer ACO that includes Medicaid is aligned with the concept for the children's system, but work must be done to fit the pieces together. She explained that prior to the final ACO design being completed, stakeholders will have input. Mr. Peltan stated that the health homes and system of care will require case navigators. Senator Hatch commented that health care reform addresses both physical and mental health and that both need to be part of the larger health care system.

Systems of Care. In response to a question by Representative Heddens regarding whether the system will address transitions for children throughout their lives, as they return from out-of-state placements, and whether the system will include children with developmental disabilities, Mr.

Peltan responded that the goal is to provide for flexibility in the development of health homes to meet the needs of the particular area in the state. The workgroup developed general principles to allow for flexibility. Ms. Vermeer noted that health homes are a way to organize and provide payment for all involved entities, and that the goal is that all systems that affect children will coordinate efforts. The Children's Cabinet should help to overcome policy and process barriers in coordinating across disciplines.

Representative Smith noted that the proposed children's system generally involves state funding from various disciplines including child welfare, mental health, and juvenile justice. Representative Smith voiced a concern regarding confidentiality of information in the children's system since when children are involved, the parents are usually given the task of keeper of confidentiality rather than the child. Representative Heaton also noted that in working across disciplines, communications may be limited unless legislation is enacted to facilitate this communication. Mr. Peltan responded that the systems of care provisions are designed to break through barriers regarding communication.

Senator Johnson cautioned that the model used for systems of care development take demographics into consideration, especially those of rural areas, and also dovetail with regionalization efforts. Ms. Vermeer noted that the role of the cabinet would include looking at these types of issues and provide solutions. Mr. Peltan noted that regionalization has worked well in north-central Iowa.

III. Judicial Branch and DHS Workgroup Report

Mr. David Boyd, State Court Administrator for the judicial branch, and Co-chairperson of the judicial branch and DHS Workgroup, presented an overview of the report, noting that the workgroup had formed in 2010 prior to the 2012 redesign and had grown to incorporate more members as necessitated by the 2012 redesign.

The 2012 workgroup was given four tasks:

1. Make recommendations regarding consolidating the processes for involuntary commitments in Iowa Code chapters 125 (substance-related disorders), 222 (persons with intellectual disabilities), and 229 (hospitalization of persons with mental illness).
2. Study and make recommendations regarding the feasibility of establishing an independent statewide patient advocate program to represent the interests of people involved in hospitalization or treatment under Iowa Code chapter 125, 222, or 229, and also make recommendations for patient advocates for those patients found guilty of a crime by reason of insanity.
3. Consider the implementation of consistent reimbursement standards for patient advocates supported by a state-funded system.
4. Consider the role of the advocate for persons who have been diagnosed with a co-occurring mental illness and substance-related disorder.

The workgroup made seven recommendations:

1. The workgroup did not recommend, at this time, the consolidation of the commitment procedures in Iowa Code chapters 125, 222, and 229, but did recommend modifying the application for involuntary commitment to be consistent across the Iowa Code chapters. One of the barriers in consolidating procedures is that there is no statewide requirement or consistent methodology for payment of services relating to co-occurring commitments.
2. Require the offer of a precommitment screening for respondents before filing an application under Iowa Code chapter 125 or 229. Pottawattamie County utilized this approach and in the first 20 days diverted eight of 10 referrals, with a projected savings of $33,000. Mr. Boyd stated that this service should be a core service at the regional level, and that it is a more appropriate use of limited resources.
3. Sunset the involuntary commitment process under Iowa Code chapter 222 for persons with an intellectual disability. These commitments are infrequent and many of those applying are served through a guardianship. The process should be phased out over a year to provide for those who do not have a guardianship or who have an ineffective guardianship.
4. Modify the involuntary commitment process under Iowa Code chapters 125 and 229 to reflect community-based services language. These provisions have not been updated and reflect an institution-based placement system.
5. The statewide mental health advocate program should be a unit of the Department of Inspections and Appeals (DIA). DIA is a statewide, independent entity that also oversees the state Foster Care Review Board and the court-appointed special advocate (CASA) program. The new unit would hire, train, and supervise the advocates and provide consistent compensation throughout the state.
6. **and 7.** Consider assignment of patient advocates for substance-related disorders and for those found not guilty by reason of insanity. These could be added after the change in oversight and payment under DIA is accomplished for those with involuntary commitments and those with mental health and co-occurring disorders.

The workgroup made five additional recommendations:

1. Funding must accompany the recommendations so the system can improve. Mr. Boyd stated that this is nonnegotiable if the system is to move forward.
2. Implement a system to identify available beds for involuntary commitments. Iowa has developed a Public Health Advanced Capacity Tracking System as a similar system for use during a disaster. The state needs a real-time tracking system to identify the type and location of beds available.
3. Justice-involved services need to be a core service including implementation of a mental health court and implementation of a jail diversion program.
4. A qualified professional workforce is necessary to provide needed services to persons with mental illness and substance-related disorders in rural and urban areas.

5. Adopt specified recommendations from the Judicial Advocates for Persons with Mental Illness organization. Appoint advocates from where the respondent resides or the court of commitment; the Iowa Supreme Court should adopt the physician reporting forms piloted in the 4th and 7th judicial districts; clarify Iowa Code section 229.19, allowing advocates to attend hearings and receive compensation for attending; and amend Iowa Code section 229.19(1)(a) to include preferred qualifications language.

Discussion:

Terminology. Representative Smith recommended that the preferred terminology be "substance-related disorder" rather than "substance-induced disorder" as was used in the report.

Precommitment Screening. In response to an inquiry by Representative Heaton regarding the precommitment screening program, Mr. Boyd provided an example of a wife and daughter who thought their husband/father should be committed. Based on the prescreening, and a conversation with the hotline, the man was determined to have early-onset Alzheimer's and was instead diverted to community services for assistance. Through the Warren County pilot, 30-40 percent of involuntary commitment filings were diverted. This is why the workgroup recommends this as a core service at the regional level.

IV. Outcomes and Performance Measures Committee (OPMC) Report

Mr. Bob Bacon, Director, University of Iowa Center for Excellence on Disabilities, and Center for Disabilities and Development, and Mr. Rick Shults, Division Administrator, Division of Mental Health and Disability Services, DHS, and Co-chairpersons of the OPMC presented the report. Mr. Bacon began by naming and thanking all of the members and noted that the OPMC was formed to make recommendations for specific outcomes and performance measures to be utilized by the MHDS regional system. The OPMC recommendations are:

1. DHS should develop an Internet-based Iowa Mental Health and Disability Services dashboard report.
2. The outcomes and performance measures used in the dashboard report should fall within the six domains of access to services, life in the community, quality of life and safety, person-centeredness, health and wellness, and family and natural supports.
3. DHS should use a survey process to collect and evaluate information directly from individuals and families receiving services and from providers delivering services.
4. DHS should convene a group of experts in survey development and outcomes and performance measures to design the survey and assist in piloting the tool.
5. DHS should develop a budget that identifies the costs of implementing the outcomes and performance measures system.
6. Only data that will be used will be collected.
7. Outcomes and performance measures should be reflective of the disability populations identified in SF 2315 and address co-occurring disabilities.

8. Future decisions should be based on the information collected from the outcomes and performance measures system.
9. Outcomes and performance measures should be evaluated across both the Medicaid and non-Medicaid systems.
10. Surveys should be conflict-free.

Mr. Bacon noted that the information should drive continuous quality improvement and be easy to read. Only data that will be used will be collected. The information would be collected at the service recipient and system levels and collected regionally, not just as a statewide sample. The reports will be updated on a regular basis.

Mr. Shults discussed implementation noting that the approach can be staged and not done all at once. DHS already has system level data available through claims data so the dashboard will be developed using this data first. Additional measures will come from subsequent data gathered by providers or regions, and from individuals and families. The department will use experts to develop and pilot the survey tool and to evaluate the results. The OPMC will continue its work in 2013 and will focus on getting input from experts in developing the measures to be used. The key message heard during the OPMC meetings is the absolute need for improved accountability.

Discussion:

Assessment Tools. In response to a question by Senator Johnson regarding appendix A of the report, Mr. Shults noted that this attachment provides examples of the types of questions by domain that the OPMC thought should be part of the service system recipient level tool. The OPMC culled questions and measures from various assessment tools identified in column 3, and "currently collected" notes whether this information is collected in an existing Iowa assessment tool.

V. Service System Data and Statistical Information Integration Workgroup Report

Mr. Shults, Mr. Robin Harlow, Iowa State Association of Counties (ISAC), and Ms. Kathy Stone, Division Director, Department of Public Health (DPH), co-chairs of the workgroup, presented the report of the workgroup. Mr. Shults noted that the workgroup divided its work between the "what" and the "how" and this report focuses on the "how." The membership did not involve as much representation from individual consumers because the work was highly technical. The workgroup has seven recommendations.

Mr. Harlow discussed the goals of the workgroup for the information system:

1. Building on what currently exists. Federal, state, and local entities have had substantial involvement in developing the necessary technology. There are issues with privacy. The workgroup reviewed what other states are doing, white papers, and other information to understand what others are doing.
2. Exchanging data within the existing systems.
3. Not causing undue burden on consumers or providers.

4. Not collecting more data than what is used and using the data that is collected. In the mental health system, there are many points of contact, but data should only be collected if it will be used. Many systems collect data points, but the narrative is also important.
5. Create a process to ensure data integrity. All groups that use the information should trust the information going in and coming out.
6. Be forward thinking and flexible. Be flexible in how to use identifiers to identify clients. This is currently prescribed in the Iowa Code and may need to be more flexible. The resources to support the system must understand mental health and be specific to mental health. Once the system is built, there must be resources to maintain the system and collect and analyze the data.
7. Determine who will report and define compliance measures.
8. Demonstrate that the public investment made is resulting in positive changes. Gather information to use. Ask what impact does collecting this data have on the client's life if the data may not be used.

Mr. Shults discussed the workgroup's seven recommendations:

1. Entities within the MHDS system will not be required to use the same operational/transactional data system. Entities are not required to change the system they have.
2. Operational/transactional systems need to have the capability to exchange information. The data systems should be interoperable.
3. The central data system should be capable of matching an individual's information from different sources using a unique individual identifier. Current law under Iowa Code section 225C.6A is fairly prescriptive, may not be the best identifier, and may need to be changed.
4. Privacy and security need to be maintained consistent with identified roles and responsibilities. There should be clearly defined use agreements.
5. DHS should house and manage the data warehouse and be given guidance from key stakeholders. Data can be accessed more quickly. Data input is dynamic and there is a lag if data is entered more frequently.
6. Efforts should be made to integrate the central data warehouse with other electronic data information exchange systems being implemented statewide. The systems should be complementary and move in the same direction.
7. An organized, coordinated effort among all MHDS stakeholders should be in place to minimize the cost of operational/transactional systems now and in the future.

Discussion:

Timeline and Third Parties. In response to a question by Representative Miller regarding the timeline and consideration of third-party management, Mr. Shults stated that there was no timeline

or cost projection yet and that the workgroup had not considered a third party since DHS already has a data warehouse available. They will also coordinate with the health information exchange through the DPH.

Integration of Information Systems. Senator Hatch noted that the individual identifier is a key phrase and asked that at the next meeting information be provided regarding how the various systems will work to integrate physical and mental health. Senator Hatch also asked that information be provided about the claims data including who has the data and whether data from private insurers can be shared.

Budget. Representative Heaton asked if Mr. Shults would come with a budget request for FY 2013-2014. Mr. Shults responded that the first year will be used to evaluate what they currently have and what the next steps are. He was doubtful that there would be a budget request this year. Mr. Shults stated that the first step is addressing the public data and later addressing the private data.

VI. Public Comment

Ms. Rhonda Shouse, a consumer who is herself and also has children involved in the mental health system, asked that the Children's Cabinet include families from across the state. She also noted that she stopped working outside the home to stay home with her child for five years. There is little peer support available and services are needed, not necessarily during regular business hours. She stressed the importance of providing Internet access to the committee's deliberations.

VII. Transition Committee Update

Mr. Chuck Palmer, Director, DHS, and Mr. Bob Lincoln, Administrator of County Social Services (CSS) Network of Counties in North Central Iowa, co-chairpersons of the committee, provided a Transition Committee update and Mr. Jess Benson, Legislative Services Agency, Fiscal Services Division, provided information about the proposed regions.

Map of Proposed Regions. Mr. Benson reviewed a map developed with Ms. Linda Hinton, ISAC, of the proposed MHDS regions. The map depicts what counties have agreed to so far, but the regions are not yet finalized. In response to a question about whether counties that are joined by only a common corner are "contiguous" as required, Mr. Benson stated that his understanding was that DHS considered these counties to be contiguous. As to counties that are not contiguous being able to form regions, Director Palmer provided that he does not have waiver authority to waive the requirement that counties be contiguous. Director Palmer stated that staff is in contact with counties on an ongoing basis and will provide technical assistance if requested. There is funding available to provide technical assistance.

Administration and Governance of Regions:

Iowa Code Chapter 28E Agreements. Co-chairperson Bolkcom asked if DHS has provided assistance for the regions to develop Iowa Code chapter 28E agreements. Mr. Lincoln noted that in forming the CSS region, he had met with their own legal counsel to develop an Iowa Code chapter 28E agreement.

Mr. Bill Peterson, Executive Director, ISAC, provided that a region's legal counsel will draft a chapter 28E agreement based on the specific decisions that a region makes. The chapter 28E agreement is shared with each county's county attorney. There are many decisions for counties to make including whether or not to pool funding and the governance structure. Mr. Peterson commented that the map of proposed regions will probably change before things are finalized on April 1, 2013.

Director Palmer stated that he hoped that counties would not wait for approval to put their plans together. His only authority is to give approval to the regions that meet the requirements and to determine when an exemption is needed. An additional issue is what to do with counties that have not affiliated with surrounding counties and are left alone.

Number of Administrators for a Region. Co-chairperson Bolkcom commented that he thought it made more sense to have one administrator for a given region for the sake of accountability and ease of administration. Director Palmer commented that the Transition Committee report will include a preliminary job description for an administrator, but does not require that a region have only one administrator. Each region must decide what is workable.

Senator Johnson stated that his main concern is protecting the individual all the way through the process, and that this is the main concern of most providers. In response to Senator Johnson's inquiries about the regional administrator position, Director Palmer noted that the Transition Committee report will include guidelines for selecting the regional administrator and that the salary of the regional administrator will be set by the regional board. As to the cap on the cost of administrative services, the department is working with LSA to determine what amount of funding would be used if a percentage cap is applied.

Mr. Lincoln noted that as the CSS region has evolved they have focused more on roles rather than positions. Some of the roles include administrator; service administrator as a separate role from funding administrator so that if this person is advocating for a client they are not making both the services and funding decisions; personnel management; and others. All remain individual county employees. CSS is working with the talent present and it is a work in progress. They have had 10 years to develop their region and it takes time. Since July 2012, CSS has grown from 8 to 18 counties. One issue for county supervisors is how to stay responsible to your own county but also invest in a joint venture.

Management of Funds. Senator Hatch commented that one of the issues with determining the appropriate distribution of state transition funding is that counties varied in their use of funds and their management of the funds, so that there was not a clear picture of where the funding was going. The goal of the redesign was not to reduce current services or place people on waiting lists, but to develop functional regions.

Mr. Peterson responded that the counties have not mismanaged services or funds, but that it is difficult for counties to plan without knowing what their budgets will be. Senator Hatch clarified that he was not accusing counties of mismanagement, but that neither the counties nor the state knew what moneys were being used for certain services. There has been an ongoing challenge for the counties because the state has never delivered on its promise to provide sufficient funding. Going forward there needs to be an understanding of how the money is used. During the transition to the

state taking over Medicaid services, it has been difficult to determine what is state or local funding. The end result is that citizens are not being served equally in all areas.

In response to a question from Representative Smith noting that the state had retained moneys previously distributed to counties in order for the state to assume responsibility for Medicaid funding but did not allow all counties to maintain their current levies, Mr. Benson noted that the difference in county funding is about $10 million. Mr. Lincoln commented that having a set per capita levy under the redesign does make it easier to project forward for the FY 2014 budget.

VIII. DHS Budget Proposal for New Regional Services Fund — Core and Core Plus Services

Director Palmer, Ms. Jean Slaybaugh, Chief Financial Officer, DHS, and a panel consisting of representatives of ISAC (ISAC panel) including Ms. Sarah Kaufman, Henry County Central Point of Coordination (CPC) Administrator; Ms. Deb Schildroth, Story County CPC; Ms. Lisa Rockhill, Lyon/Osceola County CPC; Ms. Linda Langston, Linn County Supervisor; and Mr. Peterson discussed the DHS budget proposal for the regional services fund to cover core and core plus services.

Director Palmer noted that he did not have information to report on core and core plus services, but that this would be an agenda item for the Thursday meeting of the Transition Committee. Ms. Slaybaugh provided an overview of the budget and the new MHDS regional services fund, noting that some of the drivers in the Medicaid budget have been a decreased federal match rate and the expiration of increased funds through the federal American Recovery and Reinvestment Act of 2009.

Mr. Shults noted that under the redesign there are two different funds through which funding is to be provided by the state. One is the fund to provide equalization payments to subsidize counties that will be levying at the $47.28 per capita level. The other fund is a new MHDS regional services fund to provide funding for growth and for additional core services. Ms. Langston noted the challenges that counties face in regionalizing and finding commonalities across regions in defining core and core plus services. The counties are halfway through their budget processes for FY 2013-2014 and will have to finalize their budgets before the specific core and core plus services are identified.

Ms. Kaufman noted that by nature the CPCs want to know the rules and expectations. The transition fund report recommendations were a surprise. Some regions have submitted letters of intent for regions to DHS but have not heard back, so this might be why the counties have not asked for technical assistance. The counties received an overview of the redesign law from DHS in June and the counties are using this document to plan. Ms. Kaufman understood the law to say that technical assistance would not be available until the regions submitted letters of intent in April. Director Palmer clarified that DHS would access the funding appropriated for technical assistance and provide technical assistance at any time.

Ms. Rockhill commented that the redesign legislation requires CPCs to meet certain educational requirements, so that going forward certain individuals may not be able to maintain their positions.

Ms. Langston provided that Linn County is identifying a budget based on the levy that exists today and one based on the per capita amount of $47.28. Ms. Langston noted that they have already made some hard decisions and have reduced services to maintain their system with the current funding. The biggest issue is establishing trust with the state, and counties have been waiting since SF 69 was enacted in the 1990s to establish this trust. It is a very complex system.

IX. Transition Fund Report

Director Palmer, Mr. Shults, and members of the ISAC panel discussed the transition fund report submitted by DHS on December 4, 2012.

Mr. Shults noted that the transition fund was established to provide one-time funding to counties in FY 2012-2013 for continuation of current county mental health and disability services not funded by Medicaid. The legislation directed DHS to develop and complete an application process and recommend to the Governor and the General Assembly an amount to be appropriated to the fund for distribution to the counties. The legislation included criteria that a county must meet to be eligible for the transition funds including:

1. Application and application materials submitted by the county must be approved by the county board of supervisors.
2. The county levy certified for the county's services fund for FY 2012-2013 must be at the maximum amount allowed.
3. The county financial information provided with the application must be independently verified.
4. The county's application must include all of the following:
   a. The type, amount, and scope of services provided by the county.
   b. The extent to which the county subsidizes the services directly provided or authorized by the county.
   c. The extent to which the services funded by the county are included in the county's management plan.
   d. The extent to which services are provided to persons other than adults with an intellectual disability or mental illness with income that is at or below 150 percent of the federal poverty level.
   e. A sustainability plan.

In addition, DHS established emergency rules for the application process in consultation with stakeholders, and the Mental Health and Disability Services Commission, and adopted the rules. DHS held two statewide trainings on the rules, application process, and application form, and applications were required to be submitted by no later than 4:30 p.m. on November 1, 2012.

Mr. Shults noted that the counties were not asked to identify a specific amount of funding needed but instead to provide information for DHS to determine each county's financial situation. DHS engaged a certified public accountant firm to assist in the data gathering process. Through the process, counties were asked additional questions and made adjustments to the information provided.

Thirty-two counties initially submitted applications, but six of these counties were subsequently determined not to be eligible as they had sufficient funds to pay their unpaid bills and projected FY 2013 obligations.

DHS Principles. In addition to the rules, the department developed and utilized five principles in making recommendations regarding the applications. The principles apply to all counties, not just those that made application:

1. All counties should be treated equitably.
2. Counties are expected to operate with a balanced budget each year by managing service costs so they do not exceed available revenue.
3. Counties are expected to pay all of their unpaid bills.
4. Transition funds are not to be used to pay unpaid bills from previous fiscal years.
5. Transition funds are not to be used to build a FY 2013-2014 beginning fund balance.

DHS had discussions with the counties to determine their financial circumstances, and found the following:

- The counties that did not apply for transition funds managed their service costs, maintained adequate fund balances, and paid their bills timely.
- Other counties that did not apply for transition funds managed their service costs and maintained adequate fund balances, but did not pay their state bills timely. As of October 31, 2012, these counties owed $22.1 million in undisputed state bills.
- Nearly all counties that applied for transition funds have not paid their state bills timely. These counties are expected to have a negative fund balance for FY 2012-2013 and owe approximately $26.6 million in unpaid state bills and $1.2 million in unpaid community provider bills. The application for transition funds by these counties is directly related to their unpaid bills.

Recommendation Scenarios. DHS took the information collected, reviewed the applications, and applied the rules and principles and developed three scenarios.

Scenario #1: DHS reviewed all 32 county applications and applied all of the counties' available resources to their unpaid bills and to all costs for non-Medicaid services in FY 2012-2013. This resulted in 26 of the 32 counties having projected negative FY 2012-2013 ending fund balances. The total deficit amount is $11.6 for these counties to end FY 2012-2013 without fund balances because the transition fund cannot be used to build a fund balance. DHS determined that this scenario is contrary to the principles of treating all counties equitably by having the effect of providing funding to pay some counties' unpaid bills while not others; requiring counties to operate with a balanced budget each year; using transition funds to pay unpaid bills; and using transition funds for costs that are not unintended consequences of the redesign. Additionally, the state cannot force the counties to pay their unpaid bills if they are given transition funds, and if transition funding consists of funding received by the state under the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), this money cannot be used by counties to pay the nonfederal share of Medicaid bills.

Scenario #2: DHS reviewed the 32 county applications and applied the counties' beginning FY 2012-2013 fund balances to pay down outstanding unpaid bills. These counties' remaining revenue was then applied to the cost of FY 2012-2013 non-Medicaid services. This resulted in 14 of the 32 counties having projected negative FY 2012-2013 ending fund balances and no means to pay the remaining unpaid bills. The total deficit amount is $3.8 million, and the counties still have a substantial amount of unpaid bills and insufficient fund balances to pay them. This scenario runs counter to the principles of requiring counties to pay their unpaid bills and operate with a balanced budget.

Scenario #3: DHS reviewed the 32 county applications and applied all of the counties' available resources to their projected FY 2012-2013 non-Medicaid MHDS services, but this did not provide any funding for counties to pay their unpaid bills. Under this scenario the deficit amount is approximately $1.5 million and the bulk would go to one county, Scott County.

DHS recommended scenario #3 because it came closest to meeting all of the principles.

Discussion:

Ms. Schildroth provided that funding for the transition has been uncertain from the start and that DHS has not involved the counties in the application process. Even though rules were adopted for the transition fund process, DHS developed the principles without input from the counties, and the principles are inconsistent with the rules. She cautioned that the recommendation for DHS to support scenario #3 is very concerning that if sufficient funding is not provided, counties will have to make cuts in services and may not be able to pay their bills.

Senator Hatch noted that the principles were established by DHS, not through legislation. He stated that the principle that the General Assembly was concerned with was that no Iowan was denied services or put on a waiting list, and DHS ignored this. DHS should be recommending the amount that it would take to have citizens receive necessary services and not be on waiting lists.

Senator Bolkcom reviewed the information gathered in the application process. Thirty-two counties originally applied. For counties that did not apply there is $22.1 million in unpaid undisputed state bills. For counties that did apply there is $26.6 million in unpaid state bills and $1.2 million in unpaid community provider bills. Ms. Langston noted that many counties held their state bills in order to balance the budget not knowing if transition funding would be available. DHS told counties to hold their bills so they would not run out of money.

Senator Bolkcom noted that while 32 counties put their books on the table, 67 did not. There is $48 million in unpaid state bills; primarily for Medicaid services that everyone could agree recipients received. Given that only 32 counties applied, it is hard to identify the depth of the problem. One issue is how many unpaid bills counties were holding at the beginning of FY 2012-2013 and how many are for costs accrued since the start of FY 2012-2013.

Ms. Rockhill noted, given the uncertainty, counties all approached the transition differently. The risk pool funding in FY 2011-2012 that some counties have relied on in the past for general budget shortfall could only be used for Medicaid waiting lists for FY 2012-2013.

Senator Bolkcom suggested that information is needed to determine the total cost of the bailout for counties, and that this information should include a spreadsheet with the aging of the bills and

undisputed bills. Information is also needed about the 67 other counties including how many of them are in the same circumstances as the six counties that were ineligible for transition funds because they could pay both their unpaid bills and provide services.

Representative Heaton commented that there is a shortfall in Medicaid of $48 million attributed to the county obligation for payment of the nonfederal share of MHDS services. If the counties do not pay their bills, the overall budget for FY 2012-2013 Medicaid services will be short. Ms. Langston responded that many counties held their Medicaid bills on the advice of DHS. For those counties that did not apply for transition funding, if they paid their Medicaid bills, they would not then be able to provide non-Medicaid services. Counties are receiving calls about services that have already been cut. Ms. Schildroth noted that for state bills, the providers submit the bills, DHS pays the provider, and the state then bills the county. Because of this, bills to the county may be delayed into the next fiscal year. Additionally, providers may cost settle, so finalization of some bills is further delayed.

Representative Heaton noted that once the state is handling all of the Medicaid services, they should be able to get a better handle on the costs. Mr. Shults noted that they already make projections for all of Medicaid. He also clarified that DHS drew the line on county payment of the nonfederal share of Medicaid bills on July 1, 2012, because this is when these costs became the responsibility of the state. The only bills going back to the counties now are those for services provided prior to July 1, 2012.

Co-chairperson Schulte stated that the idea was that on July 1, 2012, the state would take over Medicaid services. The transition is a challenge, but the state had to start somewhere. Linn County has been cutting back on services for two years so she is disappointed by the transition fund report.

Senator Hatch suggested that moving forward, the focus be on the 32 counties that submitted applications because the other 67 determined that they could make it without the transition funding.

Representative Heddens asked of the counties that did not pay state bills under scenario #1 how many had paid them in the past and just not this year? Director Palmer responded that DHS can provide information about the aging of the bills. Representative Heddens also asked DHS to provide more clarity about what is defined as “current core services.” She also suggested that even though CHIPRA funding may have been identified as a possible source, because funding has not yet been appropriated state general fund moneys could be appropriated instead of the CHIPRA funds, and the CHIPRA funds would then be used in another way.

Mr. Peterson reiterated that some counties held their state bills on the advice of DHS and then attempted to maintain services with the expectation that there would be funding available for this fiscal year. Some counties instead paid their Medicaid bills and cut services. If the recommendation of DHS for zero carryforward balances is implemented, it will lead to massive cuts and there will not be a stable foundation going forward for the redesign. State funding needs to be available at all steps of the redesign process to ensure success. Although $48 million seems like a lot (the amount of the unpaid bills to the state from all counties), ISAC has been asking the

General Assembly for the $40-$50 million shortfall for the last few years. He suggested that there are 99 different funding scenarios for the counties.

X. Other Discussion

County Fund Balances and Levies. Mr. Benson reviewed handouts regarding information on county fund balances and current and future levy rates. The first document he reviewed demonstrated county MHDS fund balances as of June 30, 2012, on both accrual (GAAP) and cash bases. Typically, the accrual balance is smaller. Ms. Langston noted that accrual funds generally include payments for services that are provided by other county departments.

The second document was a map denoting the counties that had applied for MHDS transition funds, whether these counties have a negative accrual fund balance, and whether the county has a current levy rate above the $47.28 per capita amount for the future.

The third document provides county levy data. The current levy generates approximately $122 million. All but eight or nine counties are levying at the maximum levy amount. There are some counties that have room under their current levy to get to the $47.28 per capita level.

Co-chairperson Bolkcom stated that by basing the system on a per capita amount of $47.28, it was just a redo of SF 69. Ten million dollars has already been taken out of the funding stream and the $47.28 supports the system as it was 15 years ago. He asked if this is really where the state wants to go. If the state wants equity, he suggested, freezing a number in place is not the answer. Co-chairperson Schulte noted that the $47.28 was a number to start with that expended the amount that was currently in the system. It was a compromise when there was no movement on property taxes. Representative Heaton added that he was excited about establishing a per capita amount because it encouraged everyone to work together and combine funds, with the understanding that in the future the amount may need to be changed. The biggest problem with SF 69, he suggested, was finding the political will to increase the amount.

Senator Hatch suggested that for the January 11, 2013, meeting, DHS and ISAC come back with recommendations so that the law does not have to be changed year after year. Representative Heddens suggested that there are other issues to consider, including brain injury and developmental disability services and that these should be included as the policymakers consider expanded services.

Information on County Budget Timelines. Ms. Langston noted that county budgets must be certified by March 15, annually, but that functionally, counties will have a budget prepared to be available for public notice on February 20 and most are already done by February 10. Mr. Peterson added that for some small counties there is a complication because they have to publish the budget in two or three newspapers of record and some are only weeklies. Counties can reduce the levy rates in their budgets after they are certified, but they cannot increase them. Another issue with the $47.28 amount is the challenge with valuations in each county which vary significantly. Some counties are valuation rich and others are poor. So, if they have a high levy, it might be due to low valuation.

Legal Settlement and Residency. Ms. Kaufman noted that a CPC group has met on legal settlement and residency and some of the recurrent questions are: What does residency mean?;

Where is the place you usually sleep for a homeless person?; What to do about kids when they turn 18 years of age; What to do about residential care facilities and state mental health institutes when you establish residency by being there; and What to do about college students.

Co-chairperson Bolkcom noted that with the veterans administration and the University of Iowa hospitals and clinics in his district, there should be a consideration of establishing legal settlement first where the services are rich.

Ms. Langston noted that supervisors in border counties are concerned as are the larger, more urban counties, and that maybe a risk pool is needed for a system based on residency.

Representative Heaton suggested that this disparity should go away once the services are the same everywhere. Ms. Langston agreed that for the core services this may be true, but that the state is inheriting the system it has built. There are greater numbers of providers in larger urban areas and it is the nature of persons in need of services to go where the services are. In the smaller counties and regions, there will still be fewer services providers.

Ms. Schildroth suggested that for counties with a large number of students at public universities who are not counted in the population, it is important to look at how their services are funded.

Senator Johnson asked how work activity services fit in to core and core plus. Ms. Langston noted that in Linn County the sheltered workshop is very important and she has suggested advocating at the federal level for this service to be including as a covered service under Medicaid.

Ms. Rockhill noted that there are viable alternatives and opportunities, but the main consideration is what each person needs. Senator Johnson shared that there are employers in northwest Iowa providing jobs such as carrying out groceries, and Ms. Langston shared the story of one young man with significant disabilities who bagged groceries and was popular with customers.

Representative Heaton stated that supported employment is a financial loss proposition for employers who lose money if there is not a funding stream to support it at an adequate level.

XI. Public Comment

Mr. Lynn Ferrell, Executive Director, Polk County Health Services, and CPC, suggested that there is a fundamental flaw in the premise for distribution of the transition funds that if a county has enough funding for the current fiscal year but no balance to carry forward, they will be okay. The bills do not stop on June 30, and if there is no ending balance, the county will not have funds to pay providers after June 30 and services will be cut. He encouraged the committee to consider the adequacy of services and funding, including for those who are considered “nonpriority” populations such as those with developmental disabilities and children. He wondered if the per capita amount of $47.28 is adequate to provide services for all populations and if any population should be considered nonpriority.

Ms. Threase Harms, representing the Brain Injury Association of Iowa and the Epilepsy Foundation, asked that the transition be fully funded and that persons with brain injury and developmental disabilities be included in the determination of core services.

Ms. Teresa Bomhoff, National Alliance on Mental Illness of Greater Des Moines and Iowa Mental Health Planning and Advisory Council, commented on the transition fund report and the future of

the redesign. She suggested that the focus not be on assigning blame, but that there be a realization that the system is going to require more funding; that the redesign should start at the current state of the system and go forward, not backward; that recipients of services and supports and their families take precedence in any decision; that counties should not be forced to have no ending balance and be broke in order to be eligible for transition funding because they will not be viable going forward; that in determining the amount and distribution of transition funding, all disability populations should be included in order for regions to be successful; and that the $47.28 per capita amount is just another frozen levy.

XII. Materials Filed With the Legislative Services Agency

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the "Committee Documents" link on the committee's Internet site:
https://www.legis.iowa.gov/Schedules/committee.aspx?GA=84&CID=849

1. December 18, 2012, Revised Tentative Agenda
2. Mental Health and Disability Services Redesign Fiscal Viability Study Committee
3. Committee Rules of Procedure — adopted December 18, 2012
4. Jail Diversion/Mental Health Courts Study, Department of Human Rights, CJJP
5. Children's Disability Services Workgroup Final Report December 10, 2012, submitted by DHS
6. Judicial Workgroup 2012 Report
7. Transition Fund Report, submitted by DHS
8. Outcomes and Performance Measures Committee Report, submitted by DHS
9. Service System Data and Statistical Information Integration Workgroup Final Report, submitted by DHS
10. Third Party Coverage Sources for Adults with DD or BI, submitted by DHS
11. Adult Crisis and Stabilization Center Pilot Report, submitted by County Social Services (CSS)
12. Regional Formation Proposal by Counties
13. MHDS Transition Fund Application Map
14. County MHDS Fund Balances
15. Updated County Levy Data
16. Iowa State Association of Counties Comments on Redesign Fiscal Viability — December 2012
17. DHS Budget Proposal on Regional Services Fund — Core Services

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