MINUTES

Mental Health and Disability Services Redesign Fiscal Viability Study Committee

January 11, 2013

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, Legal Counsel, (515) 281-3818

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

I. Procedural Business

Call to order and adjournment. The second and final meeting of the Mental Health and Disability Services (MHDS) Redesign Fiscal Viability Study Committee was called to order by Co-chairperson Bolkcom at 9:34 a.m., Friday, January 11, 2013, in Room 103 of the State Capitol, Des Moines. The minutes of the meeting of December 18, 2013, were approved. The meeting was adjourned at 4:22 p.m.

Opening comments. The Co-chairpersons thanked all those participating in the workgroups for their hard work. Co-chairperson Bolkcom stated that the focus should be on building a stronger system going forward. Co-chairperson Schulte noted that it was her last official meeting as an elected representative, but that she would be continuing to work on mental health and disability services issues.

II. Jail Diversion Program — Mental Health (MH) Courts Study Committee Report

Mr. Paul Stageberg, Division Administrator, Division of Criminal and Juvenile Justice Planning, Department of Human Rights, presented the report. The committee was established pursuant to 2012 Iowa Acts, chapter 1079 (SF 2312), an Act relating to persons with mental health illnesses and substance-related disorders. The committee was directed to conduct a study regarding the possible establishment of a comprehensive statewide jail diversion program including the establishment of MH courts for nonviolent, criminal offenders who suffer from mental illness, and to consider the feasibility of establishing a demonstration mental health court. The report states that the committee did not consider the feasibility of establishing a demonstration MH court because Iowa currently has two operating MH courts in Black Hawk and Polk counties and one under consideration. Polk County has recently received funds from the Council of State Governments Justice Center to review an MH court curriculum for developing MH courts. The report also notes that the recommendations are limited to operational issues gleaned from existing reports and interviews, and due to lack of funding, no assessment of cost or delineation of funding responsibilities or estimation of potential implementation timelines was undertaken.

Recommendations. Mr. Stageberg reported that the committee met three times and the recommendations were approved unanimously. The committee made six recommendations and focused on the population of persons with mental illness:

A. Current and Future Research

The state should utilize existing research to ensure the programs developed are consistent with best practices. The state should dedicate resources to inventory and conduct evaluations of both jail diversion and MH courts, including a cost-benefit analysis to shed light on operating a statewide system.

B. Statewide Collaboration and Partnerships

The state should bring key stakeholders together to assist in developing the expansion of services, prevention, and diversion programs. Awareness, access, communication, collaboration, and linkages should be improved across the system.

C. Prevention Beginning With the Community

Promotion of early intervention and the inclusion in recovery support of housing, transportation, and employment services should help to reduce or minimize contact with the criminal justice system.

D. Criminal Justice Diversion

The services provided should meet individual needs. Justice-involved services should be a core service including: implementation of MH courts including both diversion and conditions of sentencing models; and implementation of jail diversion programs. Mr. Stageberg offered that metro areas may have more resources available such as jail diversion and telepsychiatry. Mr. Stageberg noted that Iowa has an MH court in Black Hawk County and one in Woodbury County that operate in a similar manner as drug courts. The courts are expensive to start, but save money long-term in the system.

E. Mental Health Court Considerations

The committee recommended that the state establish MH courts, and in so doing stressed the need to address certain issues. Mr. Stageberg noted that there must be recognition of the difference of this population from other problem-solving courts. The population served must be defined. In Black Hawk County, the court began serving those with mental illness and will expand as resources are available. Voluntary participation must be ensured.

F. Funding and Responsibilities

Significant funding must be provided and distributed to the MHDS regions in order to establish a comprehensive statewide program. The committee recommended approving the Department of Human Services (DHS) FY 2015 budget request for increased funding for crisis programs and precommitment assessments. Funding should be allocated to research and assessment, MHDS regions should be responsible for implementing local programs, and treatment options and recovery supports should be available and "front-loaded" in the community to focus on early intervention.

Discussion. In response to a question by Representative Heaton regarding what effect the MH courts have on the infrastructure, i.e., what effect they have on diverting individuals from more restrictive services or placements, Mr. Stageberg responded that MH courts assist with ongoing supervision of the individual, including helping the individual to stay on their medications. When the Black Hawk County MH court was reviewed by staff, they noted that the participants were under control and could participate in the proceedings because they were taking their medications. MH courts meet over the noon hour, so they do not require additional time for the judge. In Black Hawk County, the Office of the County Attorney is represented by the County Attorney personally instead of a representative of the office. Representative Heddens cautioned that in order for the

MH courts and jail diversion to work, the community must have the necessary service infrastructure available. Jail diversion is not the program itself; the program requires services to be available in the community. Mr. Stageberg agreed that services need to be in place so that the services are available to provide early intervention and avoid jail. Co-chairperson Bolkcom noted the success of the drug courts and wondered if the judicial districts are interested in developing MH courts. Mr. Stageberg responded that the interest is significant.

III. Third-Party Coverage Sources for Adults With a Developmental Disability (DD) and Adults With a Brain Injury (BI) Report

Overview. Mr. Rick Shults, DHS Administrator, delivered the report. 2012 Iowa Acts, chapter 1129 (SF 2314), directed DHS to identify third-party coverage sources and develop estimates and financing options for maximizing third-party coverage sources for core services under the MHDS system for adults with a DD other than intellectual disability (ID) and for adults with a BI. Under the Medicaid program, "third party" includes sources such as private health insurance, Medicare, employer-sponsored health insurance, and other parties legally responsible for payment. However, following consultation with the Legislative Services Agency, DHS included Medicaid in its review of third-party coverage.

Mr. Shults explained that for individuals diagnosed with a DD or BI, third-party coverage may include coverage for regular and ongoing health care needs and health care related to their disability and for rehabilitative services, but usually does not cover home and community-based (HCBS) services, long-term care and supports, and intensive rehabilitation and recovery services and supports. The intensive care required immediately after the injury may be covered, but long-term care and supports, including occupational and physical therapies, supported community living, supported employment, crisis responses, family and peer support, case management and facilitation, respite, specialized medical equipment, and medical monitoring and treatment, are generally not covered or are limited in scope and duration. Usually, continuation of a service is predicated on whether the individual is experiencing improvement.

Autism. One service that has been discussed in the context of third-party coverage options is applied behavioral analysis (ABA) therapy for individuals with autism. In 2010, the state expanded state employee health insurance coverage to include ABA for individuals with autism. Mr. Shults noted that there has been discussion about expanding this coverage to other plans and that national studies have shown that including this coverage in the private market costs between nine and 30 cents per insured per month.

Brain Injury. Under the Medicaid program, one of the HCBS waivers is for persons with a BI. The report states that if Iowa were to expand eligibility and availability of current core services to individuals with a brain injury, expanding the BI waiver and an increase in neurobehavioral rehabilitation services should be considered. (Neurobehavioral rehabilitation services are provided by a multidisciplinary team of health and support staff trained to deliver services designed to address cognitive, medical, behavioral, and psychosocial challenges, as well as physical manifestations of acquired BI.) As of October 31, 2012, the HCBS-BI waiver had 428 individuals on the waiting list. The average cost per individual on the waiver is $22,929 annually. If the waiver

were funded to cover 50 percent of the individuals on the waiting list, the total costs in state and federal funding would be approximately $4.9 million, with the state portion being approximately $2 million. Neurobehavioral rehabilitation services for individuals with a brain injury cost approximately $687 per person per day. To serve 50 individuals, the total state and federal cost would be approximately $12.5 million, with approximately $5.2 million of the cost being state funds.

Developmental Disabilities. Mr. Shults discussed expanding the Medicaid HCBS waiver for individuals with an ID to also serve individuals with a DD that is not an ID. He explained that an estimate of the cost is difficult to project. Mr. Shults reviewed the definitions of DD (severe chronic disabilities that can be cognitive or physical, or both, that appear before the age of 22 and are expected to be lifelong) and ID (a disability characterized by significantly subaverage general intellectual functioning and significant limitations in adaptive functioning that originates before 18 years of age). Since DD is an umbrella term, some developmental disabilities are largely physical issues while others are a combination of physical and intellectual disabilities. In making its analysis under the report, DHS utilized a May 2001 article published in the American Journal on Mental Retardation that estimated at the time that the prevalence in Iowa of individuals with an ID was 23,461, while those with a DD that was not an ID was 33,989. Iowa currently covers services for persons with ID through an HCBS ID waiver that in FY 2013 is projected to cost $388.4 million in total state and federal funds, with $156.2 million being the state portion. The average cost for the 10,812 individuals on the HCBS ID waiver is $35,924 per year. It is estimated that the ID waiver covers approximately 46 percent of all Iowans with an ID. Based on the data, DHS projected that if the same percentage is applied to those individuals with a DD but not ID, approximately 15,664 additional individuals could be served by an expanded HCBS DD waiver. Additionally, the existing ill and handicapped waiver serves approximately 2,240 individuals with a DD that do not have an ID. Given these estimates, the number of individuals that would be served through an expanded DD waiver would total approximately an additional 13,420 individuals. There is no solid data to estimate the average annual cost of serving an individual with a DD that is not an ID, so DHS based its estimate on the average annual cost of a person on the HCBS ID waiver.

DHS also included in its analysis broad assumptions, including that the new waiver would be fully funded and operate without a waiting list; that the estimates provide the annual full cost of serving all of the estimated number of individuals for a year even though it will take time, maybe even years, to build to full capacity; it is assumed that the individuals would meet the level of care for the waiver; no costs to counties are included for those who would not meet the level of care; and some individuals who are eligible for the new waiver have not been Medicaid-eligible before, so this will add costs to the nonwaiver Medicaid program, which average $11,500 per individual on the ID waiver per year.

Based upon the assumptions and data, DHS projects that the total increase in costs of services to an additional 13,420 individuals on a newly expanded HCBS DD waiver would be approximately $482.1 million state and federal funds, with about $200.8 million of the total being state funds. The additional nonwaiver Medicaid costs for this population would be approximately $35.5 million total state and federal funds, with approximately $14.8 million being state funds. The costs would be lower if those eligible had less complex needs, or if the waiver focused on a smaller subgroup of persons with a DD that do not have an ID, such as individuals with autism.

Discussion. In response to Representative Heaton's inquiry, Mr. Shults stated that the projected number of 13,420 individuals would include those with a range of needs, so the cost estimates would fluctuate based on the severity of needs of the total population being served. He also noted that the waiver would cover those individuals with autism and would cover applied behavioral analysis therapy. Senator Hatch contended that since the estimates by DHS did not take into consideration private insurance coverage or coverage provided under Medicaid or Medicaid expansion subject to providing essential health benefits under the federal Affordable Care Act (ACA), DHS should be directed to redo the report. Representative Miller noted that there is a differentiation between coverage for physical and other services and that it is important to know what the high-side estimate is. Senator Hatch urged consideration of other options available and that while the state ending balance is not inexhaustible, there is some funding available if sufficient data is available upon which to make policy decisions. Co-chairperson Bolkcom agreed that the MHDS redesign conversation has been affected by the federal ACA conversation and that the report should reflect the effects of the federal ACA provisions relating to private insurance and Medicaid expansion on cost.

IV. Best Practices and Program for Persons With BI Workgroup Report

Mr. Tom Brown, Workgroup Co-chairperson, reviewed the report for the workgroup. He began by noting that with respect to third-party payment for services for individuals with a BI, prior to managed care in Iowa, private insurance covered much more. But, there was a cost shift when BI coverage was moved to managed care, and he has been asking members of the General Assembly for years to look at the issues and hold third parties accountable, especially for those with a dual diagnosis of MH/BI or substance use disorders/BI. He noted that every day in Iowa, two more individuals experience a brain injury and that is why the cost is so high for persons with a DD that do not have ID.

The workgroup presented recommendations in three sections: administrative recommendations, ranked recommendations, and recommended services currently approved to move forward. The workgroup built upon the system that has developed for years under previous administrations. Mr. Brown touched on only a few of the recommendations. Specific recommendations for funding include $95,000 to fund the position of a full-time staff person assigned to the Governor's Advisory Council on Brain Injury at the Department of Public Health (DPH) or this position will be lost; $250,000 to fund neuro-resource facilitation to reduce the need for out-of-state placement and increase the ability to bring people back to Iowa; and $65,000 to provide training to providers. Mr. Brown also urged that the waiver waiting list be eliminated and that eligibility for the waiver be determined at the time of application for the Medicaid waiver. If individuals are not evaluated and provided services immediately after an injury, there are lifetime consequences. Providing immediate services decreases expensive and untoward medical outcomes and associated secondary conditions.

Mr. Brown also encouraged expansion of community-based neurobehavioral rehabilitation services. Currently, Mr. Brown's organization is the only provider of neurobehavioral rehabilitation in the state, but additional providers could provide the service to accommodate the significant increase in utilization of this service.

V. Adult Crisis Stabilization Center Pilot Report

Mr. Bob Lincoln, County Social Services Administrator, reviewed the report. 2012 Iowa Acts, chapter 1120 (SF 2315), established a crisis stabilization program pilot project to be implemented by the regional service network. Crisis services are identified as a core service in the law and comprehensive crisis services are an expanded core service. The purpose of the pilot project was to provide a prototype for DHS, DPH, and the Department of Inspections and Appeals to develop regulatory standards for crisis stabilization services. The goal of the Adult Crisis Stabilization Center is to provide short-term support for adults who need 24-hour supervision for safety during a MH crisis, but do not require inpatient MH services. Mr. Lincoln said that a key success of the pilot project has been the community collaboration including hospitals, law enforcement, county officials, and legislators.

The center, a 10-bed facility, was established in Waterloo in February 2012. The center shares a building with North Iowa Juvenile Detention Services and is on the same campus as the Country View and Youth Shelter. The facility serves consumers who present at any of the identified access points in the community, including the four community health centers. To date, the center has served 156 individuals. The cost since expansion from a two-bed to a 10-bed facility is $225 per day and this cost can be maintained with an average census of five to seven and no MH professional on staff. The average length of stay is four to five days, and the center is used for stabilization as well as for transition.

The report recommends that crisis stabilization is an essential and needed addition to the behavioral health system. The pilot project identified the need to improve integration of care and the need to give individuals in crisis another door that is not the door to the emergency department of hospitals. The report also notes that expansion of crisis services should focus on community settings and preferably peer-run recovery-focused environments. Additionally, crisis stabilization should be connected to fully functioning access centers that act as a central intake for behavioral health services that integrates medical, psychiatric, and substance abuse services. Capacity must be increased in the community to support individuals with serious and persistent mental illness with assertive community treatment teams, and for individuals with chemical dependency, with social detoxification and sober living settings.

Mr. Lincoln noted that for the pilot project the primary intake utilized is the hospital emergency room and this should be replaced with utilization of a “front door” approach such as a prescreening for civil commitments. Senator Hatch commented that with the recent shootings in Newtown, Connecticut, earlier intervention is needed. Mr. Lincoln agreed that the center should provide a front door and could provide the evaluation of the person’s needs. He also stressed that crisis services should be more community-based and mobile. Co-chairperson Schulte interjected that the hospital intake was necessary to avoid having to develop a new licensure level which would have delayed implementation of the pilot project. The subacute level of care is more a medical level of care.

In response to Representative Heaton, Mr. Lincoln noted detoxification and MH stabilization can be provided in the same setting, but different services are required and this might involve specific licensure. Co-chairperson Bolkcom congratulated Mr. Lincoln on the success of the pilot project

and shared a constituent story. A constituent who is a doctor approached Co-chairperson Bolkcom at the grocery store to relate his experience with helping someone with an involuntary commitment. The doctor was called to the courthouse and found three others were also there to initiate involuntary commitments, but there was no place to take the person in the community. Co-chairperson Bolkcom noted that under current budget proposals the crisis system would not be funded until 2015 unless the General Assembly provides funding sooner. Representative Heaton stated that in working on the redesign, legislators were told by hospitals and other acute levels of care that 25 percent of the admissions did not need to be there. Mr. Lincoln responded that the center worked to educate the hospitals and others about the existence and availability of the pilot project service. The pilot project provided information about adjustments that need to be made to the service. For example, when working with a person with ID, there needs to be a structured setting and program in place to meet their needs as well as additional training for staff.

VI. Update on Tentative County Groupings for Regionalization

Mr. Shults and Ms. Linda Hinton, Iowa State Association of Counties (ISAC), reviewed a map depicting the most recent information regarding county groupings for regionalization. Ms. Hinton stated that the groupings are tentative and are not required to be submitted to DHS until April 1, 2013. The groupings are fluid, but two letters of intent have been received by DHS. Ms. Hinton talked about the process and the elements that can and cannot be controlled. The counties cannot control geography or the existing culture relative to provision of MHDS. One big issue is finances. There are some counties that, even with regionalization, may not be financially viable. Carroll County may ask for an exemption to forming a region and other counties may not be interested in forming a region with Crawford, Ida, and Buena Vista counties if they cannot resolve their financial issues.

Mr. Shults noted that in talking with ISAC, one issue was the provision of technical assistance by DHS to the counties. In the legislation, the technical assistance was to be provided after the counties formed regions. However, DHS has clarified that technical assistance is available to the counties at any time prior to or after submitting letters of intent. ISAC is also providing technical assistance through monthly regional discussions and help with Iowa Code chapter 28E agreements. In order for a county to be granted an exemption from regionalization, the county has to meet criteria specified in the law, such as the ability to provide core services, and that forming a region is unworkable. Both DHS and ISAC concurred that flexibility is important and that even though they will provide case examples in providing technical assistance, they will also consider variations in the counties and regions.

Ms. Hinton noted that some counties have a history of working together, but are not contiguous. Without legislation amending this requirement, DHS has no current authority to waive this requirement. At this point, Carroll, Polk, and Jefferson counties are weighing requests for exemptions from regionalization. The director of human services is given the authority under the law to make the final decision about exemptions. Co-chairperson Schulte stated that the transition committee made a recommendation to provide an appeals process to review the directors' decisions. Co-chairperson Bolkcom suggested that since the General Assembly envisioned a regional system, that the bar should be high to have an exemption approved.

VII. MHDS Funding Overview

Mr. John Pollak and Mr. Jess Benson, Legislative Services Agency, provided information on MHDS funding issues. Mr. Pollak reviewed key points and Mr. Benson described the big picture relating to the funding. Under the redesign, the state assumed a projected $239.6 million in MHDS Medicaid expenditures beginning July 1, 2012. There are issues regarding payment of outstanding bills and cash flow. Additionally, for FY 2011-2012 and FY 2012-2013, the state is providing approximately $12 million to fund individuals with no county of legal settlement. However, beginning July 1, 2013, the county of legal settlement provisions are eliminated and funding for individuals seeking treatment is based on residency.

Key Points. Mr. Pollak covered the following key points:

1. **Levy Limits.** The counties approved budgets for FY 2012-2013 in March 2012, and after that, the General Assembly enacted 2012 Iowa Acts, chapter 1120 (SF 2315). The legislation provides that for the county budgets approved in March 2013 and March 2014 for the upcoming fiscal years, the MHDS levy can be the lower of base year expenditures for MHDS as adjusted in FY 2008-2009, which was prior to state across-the-board cuts, or the statewide expenditure target established at $47.28, plus any per capita growth amount approved by law, times the county's general population. If a county's levy is above the $47.28 per capita amount, the county would have to reduce the levy. This results in up to a $10.8 million reduction in property taxes in the affected counties. If the per capita amount is below the maximum levy, and equalization payment will be provided by the state to bring those counties below the per capita amount up to the per capita amount. The total cost to the state for equalization payments is $29 million.
2. **Transfers.** Transfers between the county MH fund and other county funds are prohibited. However, the legislation did provide limited transfers for cash flow purposes for FY 2012-2013.
3. **Equalization Payments**. A county with a county population expenditure target amount that exceeds the amount of the county's base year expenditures for MHDS is to receive an equalization payment for the difference. The law provides that these payments will be distributed as specified in the appropriation made for the purposes of the payments, but the appropriations have not yet been enacted.
4. **Two-Year Period.** The per capita and equalization payments apply only to FY 2013-2014 and FY 2014-2015, and subsequently the previous cap on levies applies. No repeal is needed of the per capita methodology to go back to the previous cap.

In response to an inquiry by Co-chairperson Bolkcom, Mr. Pollak clarified that if a county lowered its cap to the per capita amount, going back to the previous cap would be an increase and the county board of supervisors would have to approve the increase.

Medicaid. Mr. Benson discussed the issues relating to the state's assumption of county costs relating to Medicaid services effective with FY 2012-2013. There are unresolved issues relating to outstanding bills for previous fiscal years and cash flow for FY 2013-2014 if the bills are paid in full.

Some of the questions are: if the transition funds are appropriated, should counties be required to pay all Medicaid bills; and should there be a cutoff date for old Medicaid bills after which time the state would take care of the cost settlement going forward. The counties will be certifying their budgets on March 1, and without transition funding or the equalization payments, there is uncertainty. Another issue is whether the per capita levy amount is the correct amount. It is also difficult to determine what the county non-Medicaid expenditures are in the state because there are variations by county. With legal settlement ending July 1, 2013, should those under legal settlement be grandparented in or should this issue be part of equalization?

VIII. Transition Fund Report

Mr. Shults, Ms. Hinton, and Ms. Jean Slaybaugh, Chief Financial Officer (CFO), DHS, discussed the transition fund report.

Ms. Slaybaugh reviewed a document on Medicaid and State Resource Center Outstanding Balances as of November 30, 2012, that are not disputed. The document includes figures for each county specifying the number of months the bills have been unpaid, the state resource center amounts outstanding and the total Medicaid, and state resource center outstanding bills, the GAAP ending balance for each county and the cash ending balance for each county for FY 2011-2012. Ms. Slaybaugh noted that many of the bills are cost-settled, that service providers are required to submit cost reports 90 days after the end of the state fiscal year, and that some of the audits take up to a year to finalize if additional information is requested. In response to an inquiry by Co-chairperson Bolkcom regarding whether the county responsibility for Medicaid bills ended on July 1, 2012, when the state took over that portion of the costs and who is responsible for costs of resource centers, Ms. Slaybaugh clarified that the state would only bill for services provided before July 1, 2012, but that bills for these services may still continue to come in. As of July 1, 2012, since all of the costs of the resource centers are Medicaid costs, this responsibility is that of the state.

Representative Smith asked for more information about Appanoose County, with bills as old as 22.7 months. Ms. Hinton responded that Appanoose County is an outlier and has just recently replaced its central point of coordination (CPC) administrator.

In response to a question by Co-chairperson Bolkcom as to recommendations for resolving the outstanding balances, Ms. Slaybaugh said that the payments for these outstanding bills are assumed in the department's FY 2012-2013 Medicaid budget. Ms. Hinton said that some of the issue is a cash flow issue, and that some of the counties are holding onto the Medicaid bills to be able to maintain services because they cannot make payments and continue to provide services. Alternatively, some counties have already cut services to be able to pay their bills. Finally, there are counties that cannot pay their bills even if they cut services. Representative Smith inquired about the legislation in FY 2011-2012 to resolve unpaid bill issues and why this is a problem again. Ms. Slaybaugh responded that the appropriation was to cover bills for services provided before FY 2010-2011 and they were disputed bills.

In response to a question about whether any counties other than the 33 that applied for transition funding might have trouble going forward because they had spent down their funds to pay for bills

or cut services to be able to pay their bills, Mr. Shults stated that he is not aware of any other counties that would need transition funds. Ms. Hinton added that she had not heard of any counties that missed the deadline nor did she feel that 15 or 16 counties will have problems in FY 2013-2014. Co-chairperson Bolkcom stated a concern that there might be more counties later in the year that might not have sufficient cash flow through June 30. Ms. Hinton noted that five counties that asked for transition funding have to reduce their levy rates, so there are concerns that even the recommendation by DHS for the highest amount of transition funding might not be enough.

Senator Hatch suggested reviewing the option of using state reserves for a short period of time to assist counties with cash flow issues. Co-chairperson Bolkcom suggested that counties have general reserves that they could use.

Legislators questioned whether DHS has legal authority to force counties to make payments if transition funding is provided, and Ms. Hinton responded that DHS has used offset in the past to recoup outstanding bills. Co-chairperson Bolkcom asked Director Charles M. Palmer if DHS is confident in its three scenarios for distribution of transition funding. Director Palmer questioned whether counties should be allowed a new application process. Representative Heddens noted that even under the most generous of the DHS scenarios, counties will have zero fund balances and this will still cause cash flow problems and wondered if the risk pool could be available for this.

Regional services fund. Mr. Shults reviewed the requirements for the Regional Services Fund, which was newly created in Iowa Code section 225C.7A to provide money for non-Medicaid funded core MHDS services for adults with a mental illness or ID that have incomes below 150 percent of the federal poverty level and are not eligible for Medicaid, and the increased costs of providing non-Medicaid funded services (i.e., growth). The DHS budget request for FY 2013-2014 is $13.4 million. Of this amount, $11.4 million is a federal Social Services Block Grant (SSBG) to support non-Medicaid funded core services and $1.9 million is for growth in county services. Of the SSBG funds, $1.1 million is to be used to pay the final state payment program claims for FY 2012-2013. The DHS budget request for FY 2015 is $37.3 million. Of this amount, $12.5 million is an SSBG to support non-Medicaid funded core services, $3.9 million is for growth in county services, and $20.8 million is state general funds for new additional core services including comprehensive crisis services that encompass justice-involved services and precommitment screening. Mr. Pollak added that the appropriation itself would provide for how the funds are distributed. Ms. Hinton added that the state payment funds are not new funds.

IX. Public Comments

Ms. Shelley Chandler, Iowa Association of Community Providers (IACP), stated that she polled her providers and that in 39 counties in the first quarter of FY 2012-2013, 158 people had been forced out of services. She suggested focusing on the individuals who have already lost services. Representative Heaton asked if the services were core or core plus, and Ms. Chandler replied that the affected individuals were forced out of sheltered employment and placed in day habilitation.

Ms. Julie Bak, Mahaska County CPC, stated that they had submitted their letter of intent last June, but that they are not sure if they want technical assistance until they know if they are approved.

Ms. Deb Schildroth, Story County CPC, directed the attention of the committee to a letter submitted by the MHDS Commission regarding the transition fund. The letter states that the commission respectfully disagrees with the department's funding recommendation and instead urges the committee to do all of the following: act quickly to get needed transition funds to counties to avoid more cuts in support services to consumers; approve an amount no less than $11.6 million; assist counties in identifying strategies to address unpaid Medicaid bills and in resolving other outstanding financial issues; and make fullest use of the available transition funds to ensure that needed services are kept in place or restored in the interest of consumers.

Ms. Teresa Bomhoff, National Alliance on Mental Illness (NAMI) Iowa, noted that the principles used in developing the scenarios for distribution of the transition funds go against the intent of the fund to build on the current system and not go backward. She suggested that all of the services in the current county management plans should be included. Underfunding by the General Assembly in the past is part of the problem and counties should not be required to have zero balances because then the regions will not be viable. Counties have a limited time period in which to use transfers from other county funds and they always must be paid back. She realizes that services are unequal in the counties, but that it will take four or five years to achieve equalization. She suggested an alternative method under which each county has at least six months of operating funds available to ensure counties can succeed the implementation of regionalization. She suggested that two requirements be placed on funds distributed: that counties are mandated to pay state bills if they are given transition funds, and if a county is not at its maximum levy amount, the county has to go to the maximum amount when the regions are operational. She wondered how things will change when legal settlement is eliminated, and whether there is adequate funding to make the change. She noted that Medicaid expansion under the federal ACA is favorable for counties and regions. Her final comment was that the per capita amount of $47.28 not be implemented as another frozen levy but that the methodology include a growth factor.

Gayla Harken, Story County Community Services and IACP, spoke about the importance of jail diversion and crisis stabilization services. She noted that Story County had to eliminate the funding for their jail diversion program because of shortage of funds. The majority of those involved in jail diversion are not Medicaid-eligible and end up in residential treatment. For crisis stabilization, services are needed in the community. Residential services are needed and funding is needed to provide the infrastructure now instead of waiting until FY 2015.

In response to a question by Senator Johnson about what happens if a county wants to leave a region after it is established, Co-chairperson Bolkcom and Mr. Bill Peterson, ISAC, both responded that the Iowa Code chapter 28E agreement would provide for this. Mr. Peterson stated that the Iowa Code chapter 28E agreement includes a term and termination clause providing the process for exiting an Iowa Code chapter 28E agreement.

X. Transition Committee Report

Director Palmer, and Mr. Lincoln, Transition Committee Co-chairs, provided an overview of the Transition Committee report. The committee made recommendations for rules for the Transition Fund; readiness criteria for operations as a region including threshold criteria; and qualifications to

apply for a waiver for a county from joining a region. The committee also made recommendations on guidance for DHS and the director on regional formation and implementation issues which include a recommendation for appeal and review of the department's decision in granting waivers, which would necessarily require legislative action. The report also includes additional recommendations for regional operations, including a job description for the regional director, a table of organization for the region, business plan components, and an administrative cost cap.

The Transition Committee also identified several areas that require legislative action. With regard to the transition fund, the committee recommended that an alternative allocation method from the one developed by the department be developed and approved to provide for fairness and not just equity, to provide fund balances for regions to be viable, and that supports the use of the entire $20 million amount that has been proposed for the transition and unintended consequences related to redesign.

The committee also recommended: that no consumer, child or adult, loses services as a result of the transition; that $47.28 per capita of the county general population be used as guidance for counties in determining their budgets; that allocation of county equalization funds should be given to a region to be shared equitably among the counties in the region; that the Legislative Study Committee establish an appeals process for counties requesting waivers from regionalization if Iowa Code chapter 17A is not effective; that the county requirement for submitting a strategic plan for FY 2013-2014 be eliminated and the county management plans stay in place during that time; that the Legislative Study Committee look at systemic barriers to implementing co-occurring and multi-occurring service development and coordination strategies; that June 30, 2013, be set as the end date for county obligation for Medicaid bills after which date the state would receive any credits and pay any obligations resulting from retroactive cost settlement adjustments; that money that is used for the current state payment program for services for individuals who are 100 percent county funded continue to be given to counties for FY 2013-2014; and that individuals in the community corrections system have access to MHDS services and appropriate funding be allocated to pay for these services.

Discussion. In response to a question by Representative Heaton regarding the required coverage of co-occurring conditions under the federal ACA, Mr. Lincoln stated that the committee's recommendation was in reference to the funding streams and the limitations on the use of certain funds for co-occurring conditions, such as substance detoxification services. Co-chairperson Schulte added that the redesign did not include the substance abuse system because the system has had an established network. However, going forward, there will have to be conversations about how to blend funding. Representative Smith commented that detoxification services are covered by the county supplemental levy, not the county general levy. He also noted that the General Assembly included in legislation that the MHIs should be staffed at capacity.

In response to a question by Senator Hatch regarding whether the cash flow issue of county balances needed until levy revenues are received was addressed in the principles developed for distribution of transition funds, Mr. Shults said that cash flow was not addressed in the principles.

Representative Heddens noted that the committee recommended that no consumer would lose services, but that as a result of the transition the system is going backward. Co-chairperson

Bolkcom noted that it is difficult to determine the cost of non-Medicaid expenses and the impact of not funding the equalization. Mr. Lincoln responded that counties have completed their budgets for FY 2013-2014 based on the cost of the first six months of non-Medicaid services and what it would cost to maintain this level of services. Mr. Lincoln commented that the per capita amount is a very reasonable amount and that there will be some property tax reductions, but also more stability.

XI. Description of Non-Medicaid MHDS Provided by the Counties and the Populations Receiving the Services

A panel of individuals representing ISAC addressed the issue of non-Medicaid MHDS provided by the counties.

Ms. Deb Schildroth, Story County CPC, provided three client scenarios for committee members to consider.

The first is a 60-year-old female with multi-occurring issues, including MH/substance use disorder and medical, who is not eligible for Medicaid. She worked in the medical field until her substance use disorder issues overcame her and she could not work full time. She applied for disability, but was hospitalized before she was approved. She was in the psychiatric unit as an inpatient and then as an outpatient. She could no longer live on her own and is in residential care. She is covered by IowaCare, so she now lives near the University of Iowa Hospitals and Clinics and has applied for disability. The county pays for her residential care, her medications, and outpatient services. The total annual amount of county funding is $40,300. If she applies and is approved for SSDI, she could be eligible for Medicaid. If she is eligible for Medicaid, she could be eligible for habilitation services as long as her income is below 150 percent of the federal poverty level.

Representative Heaton asked what the effect would be on this woman if the Medicaid expansion under federal health care reform is approved. Ms. Schildroth responded that it would depend on what is included in the essential benefits package but it could cover her medical expenses, but probably not her residential care or supported employment.

The second scenario is one of a Medicaid-eligible 18-year-old male with DD and MH/depression. He is eligible for Medicaid through the Medicaid for Employed People with Disabilities (MEPD) program. He receives social security not through a disability but as the result of the death of his father, so he is at a different income threshold. The county considered providing a 24-hour-per-day supervised apartment arrangement and day habilitation. Medicaid does not cover these and the cost to the county is $50,400 per year.

The third scenario is a 20-year-old female on the BI waiver waiting list. She has a seizure disorder and has no place to live. The county pays for her supervised apartment and for day habilitation until she can get on the waiver. The cost to the county is $40,000 per year. Her medical needs are covered under Medicaid. Representative Heaton observed that if she were on the waiver, there would be no costs to the county. Senator Hatch noted that these county expenses are local expenses that are eligible for a federal match. In addition, he observed there are thousands of Iowans who cannot get county or Medicaid services. The people on the waiting lists are getting services to the extent the county can fund them. Ms. Lisa Rockhill, Lyon/Osceola CPC, stated that

most consumers seek services at the county first because the county can connect the consumer with services. Ms. Lonnie Maguire, Shelby, Harrison, and Monona County CPC Administrator, provided that many times consumers are on all possible waiver waiting lists because the state is not sure of their disability. So some of the waivers have duplicative numbers of individuals on the waiting list.

Ms. Linda Langston, Linn County supervisor, said that Linn County and others have made critical choices in how to change their finances and services. The state offered to take over the responsibility for funding of Medicaid services, so Linn County and others moved some individuals to Medicaid services. Moving them to Medicaid services resulted in moving the person to day habilitation instead of supported employment. The county also cut other services that were non-Medicaid services such as jail diversion and transportation because they could not fund them anymore. There are some county-funded services that moved under Medicaid, but overall this is causing more cost to the system. In prior years, legislators challenged the county paying for such things as cell phones, transportation, and hotels for consumers, but individuals need to have a place to stay, a way to get to work, and a means of communication. A county paying $1,000/month is less costly than institutionalization, although some do better in supportive living.

Ms. Hinton added that non-Medicaid services allow for more flexibility due to fewer restrictions. The Medicaid waivers are a bit more flexible, but for the long term, counties need funding to provide traditional wrap-around services.

Ms. Maguire spoke about posthospitalization services and the need for counties to have funding to provide the transition services that are not covered by others. While someone is applying for benefits such as Social Security Disability Insurance (SSDI) and during a recovery period, the county covers the supports. She provided the example of a 22-year-old, homeless female with an IQ of 50, addicted to methamphetamine, and prostituting herself. She was hospitalized and after the hospitalization went to a residential care facility (RCF). The county hopes that she will be eligible for Medicaid and then the ID waiver. In response to a question by Representative Heaton, the panel members said that the county does not have control over whether a person who is hospitalized is discharged. The county does help with arranging services, but sometimes services are not in place when a person is discharged.

One of the issues with Medicaid services is that sometimes even if the person is Medicaid-eligible, the services covered might not be those that the person needs. In response to a question by Representative Smith about how the state can find out what non-Medicaid services are being provided in a particular county, Ms. Hinton responded that the majority of counties use the county services network (CSN) to track services and this system could provide such information.

Mr. Robin Harlow, ISAC, explained that each county pays claims through the CSN, but that the timing varies for each county. Over time, they will have better data and are building the capacity to have more complete data. By the end of 2013, all but a few counties will be participating, so DHS will be able to make projections. Ms. Langston noted that even though Polk, Linn, Johnston, and Scott counties are not participating in the CSN, they do report separately to DHS.

In response to questions by Representative Heaton and Representative Smith about whether the direction from DHS on payment of Medicaid bills was to all 99 counties and whether counties will eventually pay, Ms. Langston said that once the counties know that there will be transition funds, they will pay their bills. Co-chairperson Bolkcom suggested that the state wants to make sure that families get the services they need and that the funding going forward, including transition funding in FY 2013-2014 and FY 2014-2015, meets those needs. The state needs information from the counties on what the non-Medicaid expenses are. Ms. Hinton stated that counties are working on this and that some counties cut services to pay their bills and did not apply for transition funds, so it is hard to identify the amount needed for non-Medicaid services. Representative Heaton asked what services were cut by counties. Ms. Rockhill responded that some services were only cut until the person could qualify for Medicaid.

Ms. Chandler responded that of the 33 of 140 of her providers that she polled, there were a total of 158 clients cut from services, and of these, 97 were cut from prevocational services. A total of 123 were cut from work services that were county-funded and were placed in day habilitation.

Representative Heddens noted that sometimes applying for SSDI can take a long time and in the meantime the individual needs services. Some individuals may be Medicaid-eligible but are over income, so they must pay copays, and this is unaffordable for them. Ms. Schildroth stated that when a person applies for SSI, they can also apply for interim SSI, and once the person is accepted for SSI, the service funding can be recouped by the county. But, sometimes the funds are provided, but the person is not later found eligible and there is no recoupment.

Senator Hatch asked for data about the number of Iowans on waiting lists for Medicaid waivers and the number of Iowans who have received services through counties but have been terminated from the services. A subset of the second inquiry is those that need a higher level of service but are getting a lower level of service. He said that this would give the General Assembly a sense of the cost for the counties and the state. Representative Heddens cautioned that once the waiting list is eliminated, it immediately starts again.

Ms. Langston provided that redesign on its own will not fix the issue of the shortage of providers or beds. She also asked how the General Assembly will address the issue of RCFs and RCFs for persons with mental illness (PMI), since there will always be individuals who need this structured environment. There is also the issue of changing from the current legal settlement method of determining county financial responsibility to residency. The redesign is a work in progress and counties are making decisions based on incomplete information. Representative Heaton added that the state is trying to rebalance its services to be less institution-based. The state must decide how to use the federal funding provided for this purpose under the Balancing Incentives Payment Program.

XII. DHS Budget Proposal for New Regional Services Fund

Mr. Shults and Ms. Slaybaugh, DHS, reviewed the MHDS services budget history and the DHS budget request for FY 2013-2014 and FY 2014-2015 for MHDS.

Mr. Shults noted that the state will try to claim Medicaid whenever possible, but some infrastructure costs for services such as crisis services that must be maintained at all times even if a consumer is not using the service, will be funded through the general fund.

Ms. Hinton suggested that there are some variables to consider regarding the budget. One is the issue of the impending change from legal settlement to residency. There is a county workgroup developing the process for transition and she reported that they do not want something that is just legal settlement "light." Another consideration is the federal ACA, which will have a huge impact, depending on what the state does with the essential health benefits package and the Medicaid expansion. Co-chairperson Bolkcom asked if the state could come up with a range for a proposed budget, factoring in the considerations. Mr. Shults stated that counties worked hard to get the data in to the state by the end of December, and now the state can work with the data to parse out what Medicaid could potentially cover and come up with a range and some assumptions.

Ms. Hinton added that another consideration is the impact on the regions of transition funding and the lowering of levies. It is problematic for counties in developing regions when there is uncertainty about the financial status of the other counties. Counties that have current levies above the per capita amount would probably be okay if they get transition funds.

Another consideration is the definition of core services and the requirement to make evidence-based services available and how these will impact the counties.

Ms. Langston noted that there is a lack of certainty about the transition funds as the regions come together, so this makes certain counties unattractive partners. There are issues relating to RCFs and PMIs and residency that will determine how the regions form.

Mr. Peterson said that counties are trying to move forward, but there is a lot of uncertainty. The counties are not seeking unlimited state funding, but the amount a county needs to provide services fluctuates from year to year, and the counties need to have the financial basis to make decisions. They will need to reevaluate county by county and region by region how to provide services, and it might require increases in property taxes. In 1996, the funding was supposed to be a county base plus state funding. It would instill confidence if the redesign starts out with counties knowing that the state will pay the appropriate share. There is an expectation under the new system that there will be additional services, but the per capita levy amount does not meet those expectations. There are still squabbles about what will constitute core services, and there has not even been a discussion about what the core plus services will be. Mr. Peterson suggested that the General Assembly consider appropriating funds for FY 2013-2014 and FY 2014-2015 for the transition, understanding that the counties are trying to manage. If counties have additional funds, it will help them move into the next fiscal year and will also help with additional services. Mr. Peterson suggested that it would be a mistake to freeze the per capita amount at $47.28 for the next 15 years.

Co-chairperson Schulte stated that the General Assembly identified the per capita amount by estimating the amount spent on non-Medicaid services. She said that data was slow in coming, so the General Assembly limited the application of the per capita amount to two years. This forces

the General Assembly to do something or the funding goes back to the current levy amounts. There was no political will to raise property taxes, and there is a growth provision in the statute.

Representative Heaton added that the vision was that counties would join together and pool funds and equalize services. Mr. Peterson responded that each region needs to determine its service demands and build the infrastructure on a regional basis, but they do not know what the funding amounts from the state will be. He said that a per capita levy amount will not provide equity because the property values used as the basis for the property taxes vary across the state. Both the state and the counties have had fiscal difficulties since 1996. The new per capita levy amount is an interim measure but it has an impact on determining the formation of regions and the services provided. Once regions are formed, maybe an appropriate amount could be established for each region. One way to provide for a tax offset is to have property tax reductions in other areas. If costs are a county responsibility, the amount should be based on what the system actually costs the counties.

Mr. Peterson also suggested establishing a reinsurance pool like those used by insurance companies. This would provide a base amount and also a set aside for the times when costs exceed the funding available. This would be like the current risk pool and provide some protection for catastrophic expenses. Mr. Peterson noted that the per capita levy amount is not a better solution but merely a mechanism for two years and that until costs are determined, counties will always be at a disadvantage. Representative Heaton suggested that the committee review Mr. Peterson's ideas. He commented that maybe determining amounts by regions would encourage counties to pool resources. Representative Heddens added that many county supervisors are concerned about sharing property tax dollars when they form regions and they need time to get comfortable with this concept.

XIII. Committee Recommendations

Suggested Recommendations

Co-chairperson Bolkcom listed a number of potential areas for recommendation including:

- The transition fund.
- Cash flow and ending balances.
- Unpaid Medicaid bills.
- The budget proposal on the regional services fund.
- Equalization and the per capita levy.
- Continuation of the interim committee.
- Residential care.

Other members made additional suggestions:

- Representative Heaton added the issue of sheltered work.
- Senator Hatch included the list of recommendations from the workgroups.
- Representative Smith asked for consideration of children's services and the issue of confidentiality across services since parents usually are in charge of the child's

information and the state should look at youth's ability to access the information especially if self-harm is involved.

- Representative Heddens added the issue of looking at providing BI/DD services, including how to transition individuals to the adult system. There are immediate needs but also longitudinal ones. A timeline is needed for implementing this system.
- Representative Heaton noted the need for Iowa to identify essential health benefits under the federal ACA, and this must be done soon.
- Senator Hatch suggested making crisis services core services and to provide funding to ensure they are included.

Discussion of Recommendations

A. Transition Fund Amount

The committee discussed the appropriate amount for transition funding. Representative Heddens suggested the amount of $15-20 million and, if it is not needed, the additional funds would revert to the General Fund. Representative Smith noted that population changes were not figured into the equation for funding. Representative Heaton asked if federal Children's Health Insurance Program Reauthorization Act (CHIPRA) funds would be used as the funding source, and Co-chairperson Bolkcom suggested getting a recommendation from DHS and DOM on this, but that there is enough in the General Fund to provide the funding. Representative Heaton added that whatever the amount, the General Assembly would have to look at a better way to distribute the funds. Co-chairperson Bolkcom also suggested that the amount would be included in a supplemental appropriation bill, typically passed early in the session. Co-chairperson Schulte asked if Scenario 1 from the DHS Transition Fund recommendations would be the recommendation of the Committee, and Representative Heddens responded that she was not sure if $11.6 million is the correct amount. Even if it is the correct amount for those that applied, there was concern that not all counties that will need transition funds have applied. There is also a concern that some counties would not have ending balances to provide services in the next fiscal year. Co-chairperson Bolkcom added that whatever the amount, criteria for distribution would have to be developed.

Representative Heddens moved that the committee recommend up to $20 million be appropriated from the transition fund for counties to apply for and that the appropriation be included in legislation providing supplemental appropriations early in the session. The motion was seconded by Senator Johnson and was adopted unanimously.

B. Continuation of the Interim Committee

Representative Smith moved, and Representative Heaton seconded the motion, to continue the interim committee. The motion was adopted unanimously.

C. Determination of the Essential Health Benefits Package Under the Exchange and the Medicaid Program

Senator Ragan moved that the General Assembly determine the essential health benefits package early in the session for the exchange and the Medicaid program. Senator Johnson suggested splitting the motion to separate the exchange from the Medicaid program. Director Palmer noted that the essential health benefits package could be determined initially and the issue of Medicaid expansion could be decided later. The motion was adopted.

D. Unpaid Medical Bills

Representative Heddens moved, and Senator Ragan seconded the motion, that DHS be directed by the first of February to provide recommendations for repayment of unpaid Medicaid bills. The motion was adopted unanimously.

E. Cash Flow and Ending Balance

Representative Smith moved, and Senator Ragan seconded a motion, to ask ISAC to develop recommendations for addressing the ending balance and cash flow issues on or before February 1, 2013. The committee discussed the possibility of using state or county cash reserve funds and the need for counties and regions to remain solvent in anticipation of growth and expansion of services.

F. Workgroup Recommendations

The committee discussed how to approach the recommendations included in the reports of the workgroups. They discussed the need to have recommendations put into bill draft form to be able to review the recommendations. Representative Smith moved that the recommendations be drafted into a bill to be used for discussion during the session. The motion was approved.

G. Regional Services Fund

The committee determined that the regional services fund is an appropriations issue and would be discussed during the legislative session without any specific recommendation from the committee.

H. Sheltered Work and RCFs

Representative Heaton asked if there is a way to improve upon the language in the law to encourage counties with adequate reserves to continue sheltered work as they develop a new approach. Senator Johnson suggested that the references be changed to refer to work activity and not disrupt people's lives from being productive. He suggested including work activity as a core service and removing the reference to day habilitation as part of the definition of supported employment. Representative Smith moved that work activities continue to be part of the mental health and disability services system while counties formulate a new approach. The motion was approved.

Health Care Coverage

Senator Hatch spoke about plans for the health care coverage exchange and that the state-federal partnership exchange that the state has chosen is formula-based. He made a motion that the General Assembly support the Medicaid expansion to 138 percent of the federal poverty level, and Representative Smith seconded the motion. Representative Heaton responded that he could not support the motion until he had more information. He wants to discuss with IME the pros and cons of expanding Medicaid because everything has a cost. Senator Hatch noted that the General Assembly makes the decision about eligibility under the Medicaid program. Director Palmer agreed that while the Governor has veto power, the General Assembly does have a role in recommending or not recommending the expansion of Medicaid. There are implications for appropriations, but even if Medicaid is not expanded, there will be more people in Medicaid. Senator Johnson questioned whether a discussion about expansion of Medicaid was within the purview of the committee. Senator Hatch responded that it is appropriate, even if all the committee wanted was more information. The motion failed.

Co-chairperson Schulte spoke about RCFs. She said that the General Assembly did not address RCFs in the redesign legislation because the facilities vary so much and there was not a standard definition. Instead, the General Assembly decided to establish a continuum of care interim committee. The interim committee has not met and there is still not a definition. Following discussion regarding a motion on this issue, the committee determined that the issue should be addressed by the informal Senate and House workgroup. Director Palmer added that the intent was to have a group work on the issue of continuum of care, including RCFs, subacute care, and crisis stabilization.

Co-chairperson Bolkcom asked if the committee should make a recommendation on addressing non-Medicaid costs. Mr. Benson responded that he and Ms. Hinton would work to gather information during the first month of the legislative session. The committee determined that this would suffice and no formal recommendation is necessary. With regard to the issue of the levy and equalization funding that will continue for the next two years, the committee determined that ISAC should make recommendations on this issue.

Recommendations List

Following the meeting, the members of the committee considered a draft list of all the recommendations approved by the committee. The list was approved, is attached, and by this reference is made a part of these minutes.

XIV. Public Comment

Lynn Ferrell, Executive Director, Polk County Health Services, and CPC, suggested that discussion about fund balances relates to the transition fund. He said there is confusion when DHS says that the transition fund is not to be used to build an FY 2013-2014 beginning fund balance and yet the rules say that the transition fund is to provide for stability of the system beyond FY 2012-2013 and FY 2013-2014.

Pam Railsback, Long-term Care Ombudsman, spoke about concerns with RCFs. She said that many individuals consider an RCF to be their home. Counties do not consider RCFs to be a core service, but people should have the right to choose where they live. Sometimes an RCF is the only place available for a person with mental health issues. Consumers worry about the acceptance of the RCF in the community. RCFs offer stabilization and a structured environment that other options do not. Senator Johnson suggested that DHS and the General Assembly consider RCFs and RCFs for persons with mental illness (PMI) in the continuum of services.

Jim Nagle, Options of Linn County, Cedar Rapids, noted that in the 1970s educational services were supposed to be provided in the least restrictive manner. Now this is the case for MHDS. Some individuals are able to work, but due to their disability, cannot do so in a community setting. Work activity centers offer these people an option other than day habilitation to do productive work, and those who work are proud of their efforts.

Ms. Harken requested that RCFs be included in the definition of core service. She stated that day habilitation should be voluntary and county funding should provide a bridge when Medicaid funding is not available.

Diane Brecht, Penn Center, Delhi, noted that RCFs were created for a transition into the community. Mr. Lincoln is using existing infrastructure to provide crisis services, but RCFs are not an acute care setting. Without RCFs, individuals who are not Medicaid-eligible can end up in shelters with no structure and then the counties would have to fund their services. Some individuals, because of their age, go into nursing facility level of care because they are otherwise not eligible for Medicaid. The state needs to look at the continuum of care to provide the appropriate level of services. Services should be outcome-based and funding should be provided for the transition of the system.

Mr. Geoff Lauer, Brain Injury Alliance, and Olmstead Task Force, stated that third-party payment for BI services is limited and depends upon the individual showing continuous improvement. If rehabilitation and habilitation are not both covered, third-party coverage will not apply and the state will pay for the costs. The state needs to consider the benefits covered for mental health parity, behavioral health, and substance use disorders.

Mr. Mike Porter, CEO, The Pride Group, LeMars, spoke about the need for RCFs and RCF-PMIs. He said that their building dates to 1941 and that since that time, they have been providing services for persons with disabilities. When the building was constructed, there were RCFs in every county, but today, there are fewer. Due to lack of funding, he has had to take out a loan. His business provides 200 jobs in the community, and people rely on their services. He is wondering if his business can make it through the transition. He receives calls from other parts of the state needing placements and their facility is full. His business relies on the county making payments to survive.

Ms. Chandler, IACP, thanked the committee for making a recommendation to include work activity in the services provided in the MHDS system. She said that the sheltered workshops provide a bridge for those who cannot work in the community. She said that Iowa Vocational Rehabilitation

Services has a grant through the United States Department of Labor to work to improve the supported employment system.

Ms. Bomhoff thanked the committee for its work and stated that she would like the discussion on the essential health benefits to be open to families and advocates, and would like to know how families and advocates can be informed of these discussions and be part of the process.

XV. Recognition of Representative Schulte's Service to the State of Iowa

Co-chairperson Bolkcom recognized Co-chairperson Schulte and thanked her for her public service and hard work on the issues of mental health and disability services during her tenure in the Iowa House of Representatives.

XVI. Materials Filed With the Legislative Services Agency

The 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/committeeDocs.aspx?GA=85&CID=849

1. Tentative Agenda.
2. Revised Tentative Agenda.
3. Mental Health and Disability Services Redesign Fiscal Viability Study Committee.
4. Committee Rules of Procedure — adopted December 18, 2012.
5. County MH/DS Levy Law — Per Capita Levy/Equalization — LSA Legal Services.
6. County FY 2011-2012 MH/DS Ending Fund Balances — 1/9/2013.
7. DHS Budget Proposal on Regional Services Fund — ISAC comments.
8. County Adult MH/DS Service Categories and Populations Served.
9. Transitions Committee Report — January 10, 2013.
10. MH/DS System Redesign Financing Considerations — LSA Fiscal Services.
11. MH/DS Redesign Workgroups and Committee — Summary of Recommendations (Dec 2012/Jan 2013)
12. Timeline for Regionalization of MH/DS Services, submitted by DHS.
13. Initial Core Services and Eligibility, submitted by DHS.
14. Outstanding County Medicaid and State Resource Center billings, as of 11/30/2012 (from DHS).
15. MH/DS Budget History and Budget Proposal Recap — DHS.
16. DHS Budget Proposal on Regional Services Fund — 1 page summary.

17. Iowa Mental Health and Disability Services Commission — Transition Fund Comments January 2013.
18. Regional Formation Proposals by Counties — Draft Map as of 1/4/2013.
19. Recommendations Ranking — Mental Health Disability System Redesign Brain Injury Workgroup — 1/23/2012.
20. December 18, 2012 — Meeting Minutes.

https://www.legis.iowa.gov/DOCS/LSA/IntReport/2013/IPJCP000.PDF

XVII. Attachment 1 — Approved Recommendations

The Mental Health and Disability Services Redesign Fiscal Viability Study Committee discussed and approved recommendations at its final meeting on January 11, 2013. Following the meeting, the members considered and approved the following written list of recommendations:

1. That up to $20 million be designated for the Transition Fund created in 2012 Iowa Acts, chapter 1120 (SF 2315) to be available for counties to apply for in fiscal year 2012-2013. The provision for the designation along with distribution criteria should be included in legislation providing supplemental appropriations or other legislation enacted early in the 2013 Legislative Session.
2. That a request be made for continuation of the study committee.
3. That the General Assembly engage with the Governor in identifying the essential benefits package for the health insurance exchange and the Medicaid program in this state as provided for in the federal Patient Protection and Affordable Care Act (PPACA).
4. That on or before February 1, 2013, the Department of Human Services propose criteria and options for counties to repay their Medicaid and State Resource Center billings from the state at a time beyond fiscal year 2012-2013.
5. That on or before February 1, 2013, the Iowa State Association of Counties recommend options for counties to develop and maintain an appropriate ending balance for their county mental health and disabilities services funds.
6. That study committee members and other interested members of the Senate and House of Representatives continue to meet informally as a workgroup on a regular basis to continue addressing mental health and disability services redesign issues.
7. That the Legislative Services Agency prepare draft legislation to implement the recommendations submitted to the study committee by the redesign workgroups and committees so that the legislation can be considered by the informal legislative workgroup.
8. That work activity services continue to be part of the mental health and disability services administered by counties.

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