MINUTES

Mental Health and Disability Services Redesign Fiscal Viability Study Committee

October 22, 2013

MEMBERS PRESENT:

Senator Joe Bolkcom, Co-chairperson
Senator Robert M. Hogg
Senator David Johnson (via telephone)
Senator Amanda Ragan
Senator Mark Segebart
Representative David Heaton, Co-chairperson
Representative Joel Fry
Representative Lisa Heddens
Representative Kevin Koester
Representative Cindy Winckler

MEETING IN BRIEF

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

Minutes prepared by: Rachele Hjelmaas, Senior Legal Counsel, (515) 281-8127

I. Procedural Business

Call to order and adjournment. The first meeting of the 2013-2014 Mental Health and Disability Services (MH/DS) Redesign Fiscal Viability Study Committee was called to order by temporary Co-chairperson Bolkcom at 9:35 a.m., Tuesday, October 22, 2013, in Room 116 of the State Capitol, Des Moines, Iowa. The January 11, 2013, meeting minutes and the final report from the 2012-2013 MH/DS Redesign Fiscal Viability Study Committee were approved. The meeting was adjourned at 4:15 p.m.

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

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

Opening Comments. The co-chairpersons thanked everyone who has participated over the past few years who have worked so hard on the redesign. Good bipartisan work was accomplished, but the Governor did veto some ideas from legislation submitted in the 2013 Legislative Session. Senator Hogg noted he is new to the committee, replacing Senator Hatch. Senator Hogg noted that the Senate Judiciary Committee considered issues relating to the redesign last session. Our state has an obligation to serve all persons with a mental illness.

II. History of Redesign

Mr. John Pollak, Legal Services Division, and Mr. Jess Benson, Fiscal Services Division, of the LSA, provided historical and funding information on the broad policy changes made by the General Assembly relating to the state's MH/DS system during the past 20 years, leading to the most recent redesign enacted in 2012.

Mr. Pollak provided a memo to members providing historical information on MH/DS service delivery and funding. He noted that 1990s legislation provided for limited increases in county funding for MH/DS, reduced property taxes, removed supplemental levy authority, instituted the central point of coordination (CPC) system, increased Medicaid funding, and utilized managed care contracting for state expenditures.

Major concerns identified in 2009 included county legal responsibility to provide MH/DS services, but the capped county levy authority and state funding revenue shortages were inadequate to fund those services with the result that more and more counties had negative fund balances (close of FY 2007-2008, 24 counties had negative fund balances, and 28 counties had fund balances of less than 5 percent). As a result, some counties implemented waiting lists for services. The national recession in 2008 necessitated state budget cuts in FY 2008-2009. Federal stimulus moneys provided to the state for counties in 2008 through the federal American Recovery and Reinvestment Act of 2009 were projected to be $75 million from FY 2008-2009 to FY 2010-2011. Reforms from the 1990s did not address continuing inequities among the counties relating to funding, levy rates, and service needs.

Recommendations were made in 2004 and 2006 by the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury (MH/MR/DD/BI) Commission (renamed the Mental Health and Disability Services Commission by 2010 Iowa Acts, chapter 1031. Selected recommendations included considering options for rebasing county property tax funding and providing for standardized functional assessments of persons with MH/MR/DD/BI to allow for individualization of services, and increasing overall funding. Other efforts included the work of the MH/MR/DD/BI Services Funding Study Committee in 2006-2007, the Adult Mental Health and Developmental Disabilities (MH/DD) Stakeholders Task Force in 2009, and the MH/DS Study Committee in 2011 and 2012. The MH/DS Study Committee proposed several important policies that guided the redesign efforts including regionalization, core services, and the expansion of state funding. Related legislation was proposed and enacted during the 2012 Legislative Session (SF 2247, SF 2315, SF 2336, and SF 2312). Mr. Pollak also referenced a timeline prepared by the Department of Human Services (DHS) that provides a summary of significant provisions contained in the legislation and associated implementation dates for FY 2012-2013 to FY 2014-2015.

Mr. Benson presented a chart that shows a history of state appropriations distributed to counties for the county MH/DS system from FY 2000-2001 to FY 2013-2014. The chart illustrates that state funding for the Adult Disability Services system has fluctuated over time with more new money appropriated in good years and reductions occurring during recessions. The chart shows that most of the funding streams over time were relatively stable with the exception of the Allowed Growth Appropriation which fluctuated with the state's financial health.

What the chart does not show is that during both recessions in the early 2000s and from FY 2008-2009 to FY 2010-2011, the state received an enhanced Federal Medical Assistance Percentage (FMAP) rate which took some pressure off the state to provide counties with allowed growth funding, but left a significant hole for the state to fill when the extra federal financial resources were eliminated in FY 2010-2011.

Once the state took over Medicaid beginning in FY 2012-2013 (orange bar at the right of the chart), the only appropriations that the counties receive are from the federal Social Services Block Grant (SSBG) and from state equalization payments. The SSBG money was used to pay for the now phased-out State Case Program (State Payment Program (SPP)) for adults who did not have a county of legal settlement. Because legal settlement was eliminated on July 1, 2013, those dollars are distributed to the same counties that received those funds in FY 2012-2013. State equalization payments for non-Medicaid services will be distributed in FY 2013-2014 and FY 2014-2015 to the 54 counties whose (county property tax) levies are less than $47.28 per person living in the county.

Discussion. In response to a question by Senator Segebart as to where Iowa ranks as far as the FMAP rating, Mr. Benson responded that 20 states have FMAP ratings lower than Iowa. Senator Hogg asked whether there is a good growth model measure in place for assessing the demand for services as the redesign is taking place. Mr. Pollak responded that there is a need for an accurate database and he is hoping this interim will help improve the data system. Representative Winkler asked about the $47.28 per capita and whether growth is built into the levy limit. Mr. Benson responded that the $47.28 funding formula was arrived at based upon the need for services when

the formula was enacted in 2012, and the per capita levy limit will sunset after FY 2014-2015. There may be a need to review and reauthorize this equalization figure, and a growth model could be built into that, although state money may be freed up with the implementation of the Iowa Health and Wellness Plan (which is replacing the IowaCare Program set to expire on December 31, 2013), a new Medicaid program created to provide comprehensive health care coverage to low-income Iowans as part of the federal Affordable Care Act. Co-chairperson Bolkcom commented this committee will spend a significant amount of time on a discussion of funding needs and concerns, especially at the second meeting in December. Co-chairperson Heaton noted that the committee needs additional information on the appropriate amount of money necessary to provide the appropriate services.

III. Mental Health and Disabilities Workforce Workgroup Preliminary Report

Dr. Marinette Miller-Meeks, Director of Public Health, presented draft recommendations from the Mental Health and Disabilities Workforce Workgroup, created in 2012 to make recommendations to the legislature regarding Iowa's mental health professional workforce. The workgroup began meeting in 2012 and is required to submit a final report to the legislature by December 16, 2013.

Dr. Miller-Meeks shared statistics relating to the number of licensed mental health professionals (psychiatrists, psychologists, physician assistants, licensed social workers, and advanced registered nurse practitioners) working in Iowa and emphasized that Iowa's statistics provide an extreme example of the national mental health professional workforce shortage crisis. As an example, Iowa has 238 licensed psychiatrists but should have 400 and Iowa ranks at the bottom in the number of psychiatrists per capita. Providers are not distributed equally throughout the state.

Contributing factors toward this workforce shortage include the length of time it takes to educate, train, and license mental health professionals particularly at the masters and doctoral levels, scope of practice issues including the lack of prescribing authority for psychologists, rural provider and practice issues, low reimbursement rates, the high costs of education, student loan debt, and the lack of state funding for loan repayment programs.

Dr. Miller-Meeks noted that a partial solution may be to expand the role of primary care providers in screening and managing persons with chronic mental illness but this would require improved training curricula and continuing medical education. The use of expanding technology such as telemedicine services is another resource to address rural area provider shortages. She emphasized the importance of a team-based approach for the mental health workforce in Iowa. She also noted that nonlicensed mental health care providers including peer advocates and direct care workers serve important and critical roles as members of the provider team and should be better integrated into the provider team.

Dr. Miller-Meeks presented overall draft recommendations from the Mental Health and Disabilities Workforce Workgroup (in no particular order of priority) as follows: Improve the mental health and disabilities training of primary care doctors and other primary care providers; develop a systems approach and incent the use of a team to improve treatment services, monitoring, and case management of those with mental illness or with co-occurring mental illness or substance use disorders; review licensing and credentialing eligibility criteria to assess the necessary workforce

that would best meet Iowa's provider needs; provide a plan for provider service needs over the next 20 years; and identify and implement strategies to fix system problems that inhibit the production of service providers.

Discussion. There was significant discussion from members concerning system needs for midlevel and unregulated service providers in addition to licensed primary care professionals, and regarding the role of higher education and training requirements of various professionals. Representative Fry asked how Dr. Miller-Meeks is facilitating the involvement of licensure boards into the conversation as there is a need for licensure rules to be consistent. Dr. Miller-Meeks agreed there are inequities between licensing categories and it is important to involve the licensing boards in the discussion. A statewide licensing policy review is necessary. It would also be helpful to look at what other states are doing in regard to licensing. Representative Heaton noted the importance of telemedicine as a resource for mental health providers and the need to address private insurance coverage issues relating to the use of telemedicine. Representative Heddens expressed concern about the high turnover rate of unlicensed direct care providers.

Senator Bolkcom noted that the recommendation relating to improving the mental health and disabilities training of primary care doctors and other primary providers should be a priority especially in light of the implementation of the federal Affordable Care Act (ACA). Representative Heaton commented that the services of psychologists should be a part of the SIM (State Innovation Model) initiative (to accelerate and test new payment and service delivery models under the ACA through Medicaid). Issues relating to current reimbursement models will therefore change over time. Dr. Miller-Meeks responded that the current system is based upon current practices and the issue is really whether a growth model was utilized in determining service needs.

IV. Status of Redesign Panel

This panel consisted of Mr. Rick Shults and Ms. Jean Slaybaugh, DHS; Mr. Russell Wood, Franklin County, CPC administrator; Mr. Rod Sullivan, Johnson County Supervisor; Ms. Linda Hinton, Iowa State Association of Counties (ISAC); and Mr. Benson. Mr. Geoffrey Lauer, Executive Director, Brain Injury Alliance of Iowa, and Mr. Richard Shannon, Public Policy Manager for the Iowa Developmental Disabilities Council.

The panel distributed material and responded to questions concerning the current county groupings to form regions under the redesign, Transition Fund expenditures to maintain service levels in FY 2012-2013, the status of unpaid Medicaid and other bills owed to the states by counties, the status of the per capita funding to equalize funding between counties, the listings of services comprising the core services to be implemented during FY 2013-2014 and "core plus" services which may be implemented as funding is made available by the state, the status of the change in the process to determine government responsibility for an individual's MH/DS funding from an approach based upon legal settlement to residency, and other concerns.

Regions. Mr. Shults commented that the new regional system is in place and that this was the result of a lot of hard work on the part of counties and county boards of supervisors. He distributed a map of the 15 new MH/DS service regions (county groupings or regions). He noted that Polk County was the only county to receive a waiver to operate as a single-county region. Jefferson

County in southeast Iowa has appealed the DHS decision denying the county's request to be exempted from the requirement to enter a regional service system. The administrative law judge is expected to issue a decision by December 31. All other counties have been approved to participate in a region. Iowa Code chapter 28E agreements for the approved regions are waiting for DHS approval.

Transition Fund Expenditures. Ms. Slaybaugh presented information on Transition Fund expenditures to date. In 2013 Iowa Acts, chapter 131 (HF 160), a transfer of approximately $11.6 million was made from the federal Children's Health Insurance Program (CHIP) contingency fund to DHS to be credited to the Transition Fund created in the redesign legislation to support the costs of services in current county management plans (until replaced by a regional plan). The moneys were appropriated from the Transition Fund to DHS for allocation to counties that applied for assistance from the fund and were identified in the DHS Transition Fund Report, Recommendation Scenario 1, submitted in December 2012. Twenty-six counties were identified to receive transition funds and payments to these counties ranged from $1,817 to $2.4 million during FY 2012-2013. DHS was required to enter into agreements with counties to support compliance with federal restrictions on the use of CHIP contingency funds. FY 2012-2013 was the applicable fiscal period for use of the transition funds and to her knowledge, all funds were projected to have been spent during that period.

Status of Unpaid Medicaid and Other Bills Owed by Counties to the State. Ms. Slaybaugh noted that on the issue of counties that have unpaid Medicaid or other unpaid balances for the nonfederal share of Medicaid services funded in previous fiscal years, the balance of $32.2 million owed at the end of May 2013 had been reduced to $5.8 million as of October 2013.

Equalization Payments. Ms. Slaybaugh noted that 54 counties that have county populations that when multiplied by the $47.28 per capita levy limit total more than the amount of the county's base year expenditures for MH/DS and will be receiving equalization payments for the difference. The distributions are to be made so that each county is spending $47.28 per capita when a county's MH/DS property tax levy and the state's equalization payment are combined. This per capita levy/equalization payment approach applies only for FY 2013-2014 and FY 2014-2015, then the previous levy cap applies again. Forty-five counties do not receive any amount of equalization payment because their capped property tax levies are equal to or exceed their total authorized per capita expenditures. Ms. Hinton expressed concern about eight counties that have not received equalization payments because they have not agreed to a payment plan for an unpaid balance and therefore DHS has not been able to approve the payment plans. These counties also owe more than they will receive in equalization. Ms. Slaybaugh noted DHS has had to recontact several counties to get county finance information and that they are working with the counties to negotiate the payment plans. Several counties had requested a quarterly payment plan and Co-chairpersons Heaton and Bolkcom asked that DHS be flexible in working with the counties on payment plans.

Core and Core Plus Services. Mr. Shults noted the initial core service domains as specified in Iowa Code section 331.397(4) will include treatment, basic crisis response provisions, community living support, employment support, recovery services, and service coordination. The proposed

timeframes from the redesign legislation enacted in 2012 did not match up with reality as the core services went into effect before the regions were organized. This implementation issue was corrected during the 2013 Legislative Session by authorizing committees to continue using their existing service management plan until it is replaced with a regional plan. DHS rules defining core services and addressing other issues like access to services as well as ensuring consistency between Medicaid and non-Medicaid services are in the final phase of being adopted.

Co-chairperson Heaton expressed concern that one of the ideas in redesign is to ensure that persons currently receiving services not lose those services. Language in core service rules authorize persons who are not included in the mental health or intellectual disability service populations to continue receiving services provided funds are available to do so without limiting or reducing core services.

Committee members also expressed concern about the fact that services for adults with a Developmental Disability (DD) is not a core service although a lot of counties are serving this population. Co-chairperson Bolkcom stated he sees DD as an additional core service rather than as an expanded service. Representative Fry commented about the need to be careful about the rhetoric relating to waiting lists and the denial of services as these terms send the wrong message to potential consumers. Mr. Shults clarified that the current DHS budget proposals for FY 2014-2015 do not include funding to support core or core plus services due to the fact that it is difficult to budget for this until Medicaid expansion occurs. Advanced crisis intervention approaches such as mobile crisis teams would be classified as a core plus service and are not required without additional funding. Committee discussion also focused on the uncertainty as to how the new Iowa Health and Wellness Plan will impact the new regional system and DHS believes counties are best situated to estimate the impact. Representative Koester raised the issue of the use of evidence-based practices and strategies in the delivery of mental health services that reflect the best research available. Mr. Shults responded that nothing would prevent a region from going above and beyond using evidence-based practices. Committee members agreed that collecting data and sharing data pose significant problems for policymakers due to privacy concerns and that implementation and funding of a subacute level of care continues to be a significant need.

Transition from Legal Settlement to Residency. Ms. Hinton commented that with the legislative change from legal settlement to residency to determine county or state financial responsibility for service costs effective July 1, 2013, and the issue of who pays for non-Medicaid services, budget adjustments may be necessary to address the status of children, out-of-state persons who are present in this state for services, services provided in the dual diagnosis program at Mount Pleasant State Mental Health Institute, the status of homeless persons, and the attraction of new residents to “service rich” counties.

Brain Injury and Developmental Disabilities. Mr. Lauer noted that there are currently 95,000 Iowans with long-term disabilities relating to brain injury (BI). He provided data on BI services showing that over 800 persons are on the state waiting list for the Medicaid BI services waiver and have been there for more than 18 months. A supplemental state appropriation funding was requested to address this waiver waiting list early in the 2014 Legislative Session. On the positive side, he noted that one region has declared a commitment to providing core services to persons

with BI and that legislation from the 2013 session "resulted in brain injury being recognized as a co-occurring condition meriting a basic capacity response as well as the identification of a standardized assessment tool for brain injury." He expressed concern about the effect of the 80 percent clawback requirement relative to Medicaid services provided through the Iowa Health and Wellness Plan that reflects savings to counties that may undermine the purpose of redesign to provide more effective, efficient, and accessible MH/DS services to consumers. He recommended elimination of the clawback and redirecting the savings back to the counties to improve regional services. He noted that administrative rules allow regions to provide services to persons with BI if funds become available without limiting or reducing core services. Mr. Shannon noted there is no Medicaid developmental disabilities (DD) waiver, unlike the BI waiver. The access for persons with DD for any level of service is very limited.

In response to Representative Heaton's question relating to a region's ability to provide DD services, Mr. Shults acknowledged this is a concern and that a region can continue BI and DD services only subject to available funding. Co-chairperson Bolkcom would like to see DD included as a core service rather than as an expanded service. Committee members discussed the need to strengthen language for the regional system to provide services to persons with BI injury and to persons with a DD other than an intellectual disability. Committee members also expressed concern about the lack of adequate data to identify savings when counties have more complete data than the state does.

Committee discussion also addressed the concern that the county-based MH/DS system has been under significant stress with annual major changes and it was suggested that the system be allowed time to adjust to the existing changes before new major changes are added. Mr. Wood noted that Franklin County starts the budgeting process soon and that the statutory budget requirements provide for county budgets to be finalized by March, far ahead of when it is known what the state budget will be. It has been difficult for many counties to know how to plan and budget with so many big changes affecting the MH/DS system.

V. Integration Between Regional System and Medicaid

This panel included Ms. Jennifer Vermeer, DHS Medicaid Director; Ms. Maria Montanaro, CEO, Magellan Behavioral Health of Iowa; Mr. Jim Rixner, Executive Director of Siouxland Mental Health Center; Mr. Lynn Ferrell, Executive Director, Polk County Health Services; and Ms. Hinton and Mr. Shults. The panel focused on new Medicaid program coverage options being implemented as the Iowa Health and Wellness Plan under the federal ACA, and the phase-in under Medicaid of integrated health homes for children with serious emotional disturbances and adults with chronic mental illness by the managed care contractor, Magellan.

Medicaid and Iowa Health and Wellness Plan Benefits Relevant to the Regional MH/DS System. Ms. Vermeer presented a benefits comparison chart comparing the Medicaid State Plan and the Iowa Health and Wellness Plan (IHAWP) which also included mental health, substance abuse treatment, and support services plan benefits. IHAWP was enacted to provide comprehensive health coverage for low-income adults ages 19 or younger who are not already Medicaid-eligible with income up to and including 138 percent of the Federal Poverty Level (FPL).

Iowa law specifies 133 percent of the FPL but allows for the use of the income disregard provision under federal law which has the effect of increasing the income limit to 138 percent of the FPL. This plan replaces the IowaCare Program which ends December 31, 2013. The IHAWP has two options that focus on improved outcomes with incentives for healthy behaviors, an emphasis on care coordination, and provision of local access to care: The Iowa Wellness Plan for adults ages 19 through 64 with incomes up to and including 100 percent of the FPL and the Marketplace Choice Plan for adults 19 through 64 with incomes from 101-138 percent of the FPL. The Iowa Wellness Plan will be administered by the Iowa Medicaid Enterprise and offers benefits similar to the state employee health plan. Under the Marketplace Choice Plan, members select a certain private health plan available on the Health Iowa Marketplace and the Medicaid program pays the premiums to the private health plan on behalf of the member.

Under the overall approach, persons with an income below 138 percent of FPL with various serious conditions who are determined to be medically exempt will be eligible for benefits under the traditional Medicaid program. A member who is medically exempt and eligible for traditional Medicaid coverage may instead choose to be enrolled in the Iowa Wellness Plan or the Marketplace Choice Plan, as applicable. Under federal requirements, the medically exempt status is referred to as "medically frail" and applies to persons with any one or any combination of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living; or 5) a determination of disability based on Social Security Administration criteria. A scoring system is applied to determine if the condition is serious enough to justify the exemption. The Iowa Medicaid Enterprise is implementing strategies to identify medically exempt individuals at enrollment, by referral, and through retrospective claims analysis.

Co-chairperson Heaton asked about private insurance copayment requirements creating a barrier to services but copayments are not authorized under IHAWP except for nonemergent emergency room visits. In response to a question about whether midlevel practitioners will be covered under the provisions of private plans, Ms. Vermeer responded that DHS does not have a regulatory role in this and that state law and insurance regulation should determine whether insurance practices for credentialing service providers create barriers to providing coverage under the private health insurance plans.

Ms. Vermeer noted that Iowa Medicaid is automatically enrolling the 63,000 persons who are currently enrolled in the IowaCare program that is being replaced by the new plan. Individuals can claim a hardship exemption to premium requirements and the exemption is similar to the one under IowaCare. The first 12 months of premiums can be waived if members engage in certain healthy behaviors.

Integrated Health Homes. Ms. Montanero spoke about Integrated Health Homes (IHH). An IHH is a program for Medicaid-eligible adult members with serious mental illnesses (SMI) and children/youth with serious emotional disturbances (SED). The approach uses a team of care coordinators that includes nurses, social workers, and peer and family support specialists to assist members with holistic care coordination and health and wellness education. This program is

administered through Magellan Behavioral Care of Iowa, a specialty health care management organization. Magellan held information meetings for providers, county officials, advocates, and other interested parties to discuss the IHH model, including expectations for IHH providers, and to answer questions. IHH providers (local agencies that have expertise in serving people with mental illness) provide the following services relating to comprehensive care management: care coordination; health promotion and wellness prevention activities; comprehensive transitional care; individual and family support services; and referrals to community and social support services. The IHH will serve persons enrolled in Medicaid and includes persons currently receiving Targeted Case Management (TCM) services through Medicaid.

Ms. Montanero stated that a phased-in enrollment in IHH's for adults with an SMI and children with an SED began on July 1, 2013. Phase 1 began in Linn, Polk, Warren, Woodbury, and Dubuque counties on July 1; phase 2 will cover other areas in spring 2014; and phase 3 will cover the rest of the state beginning July 1, 2014.

Mr. Rixner spoke about the implementation of an IHH in Sioux City through the Siouxland Community Mental Health Center. He stated his community's experience has been very positive as the enhanced level of support from the hospitals as part of the IHH implemented in Sioux City has enabled the hiring of a new psychiatrist, and early outcome data from pilot projects indicates reductions in the usage of an acute level of treatment.

Mr. Ferrell raised a number of questions about how low-income persons will engage with the new IHAWP and the potential effects on regional services, initial performance issues with implementation of the IHH, and limitations on county access to service information on clients when the state assumed payment responsibility for the Medicaid services provided to those clients. He also raised issues relating to the transition, including access to information, addressing the shift in attitudes of some providers, residency, placements, and adequate measurements relating to service delivery.

Co-chairperson Heaton commented that DHS needs to adequately address the impact of the IHAWP on the counties. Co-chairperson Bolkcom asked when the regional advisory committees would be in place and Mr. Shults responded they should be in place no later than April. Co-chairperson Bolkcom also raised the issue of information sharing given the federal Health Insurance Portability and Accountability Act (HIPA law) and other privacy issues, and Ms. Vermeer responded that her office is in the process of determining how data will be shared between regions for system coordination and service planning.

VI. Residential Care Facilities and Work Activity Programs Panel

This panel consisted of Mr. Dan Strellner, Abbe Center, Cedar Rapids; Mr. Terry Johnson, CEO, Genesis Development; Mr. John Severtson, Opportunity Village, Clear Lake; Mr. Barry Whitsell, CEO, Village Northwest Unlimited,; Ms. Lynn Bopes, CPC, Jackson County; Ms. Sharon Nieman, CPC, Plymouth County; Ms. Shelly Chandler, Iowa Association of Community Providers (IACP); Ms. Hinton, ISAC; and Mr. Shults, DHS.

Residential Care Facilities. Mr. Strellner noted that RCFs and RCFs for Persons with Mental Illness (PMIs) were once county homes that provided very basic custodial services for indigent individuals and persons with intellectual disabilities. Many of Iowa's RCFs and PMIs now provide active treatment services as an alternative to inpatient hospitalization, homelessness, nursing home placement, incarceration, and MHI placement. The majority of persons in RCFs have a diagnosis of mental illness. Mr. Strellner expressed concern about the continued existence of RCFs as there has been limited discussion about the role of RCFs and PMIs in the MH/DS redesign and RCFs and PMIs have not been designated a core service. There has been pressure to downsize RCFs and PMIs and shift operational costs from counties to Medicaid habilitation services funding. If the goal is to downsize these facilities, there is a need for a long-term, strategic plan to serve these populations with appropriate and flexible financial resources. He suggested the state could support such efforts by convening the Continuum of Care and Subacute Planning groups, working closely with providers to develop a comprehensive plan for downsizing, working with providers and regions to develop a funding services plan, and establishing a state-sponsored fund to help facilities downsize to Medicaid-eligible size.

Mr. Severtson spoke about Opportunity Village's housing transition project transitioning persons from larger RCFs to smaller homes. Opportunity Village, located in Clear Lake, is a private, nonprofit, charitable organization dedicated to serving people with intellectual disabilities. The village's first priority in the next four to five years is finding appropriate housing in communities for about 75 people who currently live in seven cottages that each house up to 16 people on the village's main campus in Clear Lake. These homes will be closed and residents will be moved into four-and five-person homes over the next four years. Mr. Severtson stated Opportunity Village is not a typical Home and Community-Based Waiver Services provider in Iowa and has been very fortunate to have strong community support including generous financial support from local donors. Without significant capital buydowns, this type of project would not be financially feasible. Ms. Chandler emphasized that as a result of the redesign, 3,000 persons who are currently in RCFs have been placed in jeopardy of being evicted from their homes.

Co-chairperson Bolkcom commented that there is a need to avoid situations like the Abbe Center experience where a reduction in county funding and the uncertainty of the redesign forced the RCF to close this past fall. We need a thoughtful approach like Mr. Severtson's approach with Opportunity Village. Representative Fry asked how DHS has responded to situations such as these, and Mr. Shults responded that there has not been any significant change in DHS policy in this regard. Ms. Nieman and Ms. Bopes both commented they cannot predict if RCFs or workshops will be a part of their regions as the regional boards will be making this decision and the adequacy of funding for core services is a major issue. They expressed concern about the lack of access to services certain populations will have and those persons may end up homeless.

Work Activity Programs. Mr. Whitsell spoke about Work Activity Programs and the concern that work activity services were not identified under the redesign to be a core service. Work activity services provide work opportunities in residential and vocational settings for adults with intellectual and developmental disabilities or a traumatic brain injury. Since work activity was not included as a core service, these programs are subject to being eliminated by regions due to budget

constraints. Mr. Whitsell spoke about his experience as CEO of Village Northwest Unlimited, which provides a continuum of services to 175 people on a daily basis.

Mr. Shults noted that work activity program services are not prohibited for coverage under the regional system as nothing in the redesign says regions cannot use their moneys to pay for anything Medicaid does not pay for. However, some panelists advocated for including these services as specific core services so they are not crowded out by other core services and provided specific examples of this effect. There was much discussion regarding the value of work in providing meaning and purpose to persons' lives.

Mr. Johnson commented about the positive effects work activity residents have on local communities. People with disabilities deserve the right to work to give purpose and meaning to their lives and to be a part of their chosen communities. The decision to exclude work activity centers from being defined as a core service devalues the services residents provide to the community. We need a partnership to move forward.

Co-chairperson Heaton commented there is a need to make sure that incentives are out there to keep this population in our local communities. DHS needs to move forward with a supportive program that works with the provider community. Panelists also noted the positive effects of recent efforts by the Vocational Rehabilitation Division of the Department of Education in realigning incentives for providers of work activity programs to MH/DS populations.

VII. Public Comment

Mr. David Pinkerton, a consumer, stated that he has done research on the effects of neurotransmitters on a person's mental health. His concern, based upon personal experience, is that there is no verifiable testing protocol in place to accurately identify mental illness in a person. He believes the focus of the discussion should be on what causes mental illness and how mental illness can best be treated. An accurate diagnosis makes all the difference.

Ms. Shelly Chandler, IACP, stated that there are 30,000 direct care workers who do not have licenses or certifications but who provide necessary MH/DS services who provide the crux of MH/DS and the current provider system needs to address this concern. She noted that in the first quarter of FY 2012-2013, 158 people had been forced out of services because of the unintended consequences of the redesign. She noted the importance of keeping the focus on people who need the services instead of just focusing on the financial concerns.

Mr. Allen Fager, a consumer, commented about his personal experience as a parent of a child with Down's Syndrome. He commented about the changes he has seen in program disabilities support services through the years. There are gaps in services. He has worked in the industry and has been involved in disability programs. Big changes are taking place. He supports the classification of work activity as a core service. There is a need to take a strong look at the definition of core services.

Ms. Karyn Walters, Polk County Health Services, commented that the core service domain is not a limited list. We need to make sure the Olmstead principles are driving the system changes. We

also need to fill the gaps to make sure everything is working together as Medicaid is not the answer for everyone needing services.

VIII. 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. October 22, 2013, Tentative Agenda.
2. October 22, 2013, REVISED Agenda.
3. Briefings on Meetings 10/30/2013, 11/06/2013 Mental Health and Disability Services Redesign Fiscal Viability Study Committee.
4. Briefings on Meetings 01/24/2013, 06/19/2013 Mental Health and Disability Services Redesign Fiscal Viability Study Committee.
5. Interim Committee Reports 08/16/2013, 10/16/2013.
6. 2013 Final Committee Report — Draft.
7. ISAC Analysis and Map — County Funding of NonMedicaid MH/DS — FY 12.
8. ISAC Recommendation on Appropriate Level of County Services Fund Reserves**.** Interim Committee Reports 2-6-2013.
9. DHS Analysis — County Funding of NonMedicaid MH/DS — FY 13 and Beyond.
10. DHS Analysis of County Funding — Appendices 1 and 3-6.
11. DHS Analysis of County Funding — Appendix 2 (8.5x14 landscape).
12. Recommendations of the Mental Health and Disability Services Redesign Fiscal Viability Study Committee.
13. Residential Care Facility Information from IA Assoc of Community Providers.
14. Sheltered Work Information from IA Assoc of Community Providers.
15. Behavioral Health Workforce Recruitment and Retention — NCSL Memo.
16. Map of Approved MH DS Regions — Aug 2013 - from DHS.
17. MH & Disability Services State Funding FY2001-FY2014 — LSA Fiscal Services.
18. MH DS Redesign Historical Information — LSA Legal Services.
19. Transition Fund for FY 2012-2013 — Key Points - DHS.
20. Per Capita Equalization & Upaid Billings Summary as of Oct 2013 — DHS.
21. Transition from Legal Settlement to Residency — ISAC.

22. IA Health & Wellness Program — Medically Frail/Exempt Individuals — DHS.

23. Medicaid/IA Health & Wellness Plan Benefits Comparison — DHS

24. Mental Health & Disabilities Workforce Wkgroup Draft Recommendations - DPH.

25. Regional Core Services — Statute and Rules as of Oct 2013 — LSA.

26. Advocate's Guide to Mental Health & Disability Services Redesign - ID-Action.

27. Integrated Health Homes slides — Magellan Behavioral Care of IA.

28. January 11, 2013, Minutes.

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