Iowa Department of Human Services

Iowa Mental Health and Disability Services System Redesign Final Report

December 9, 2011

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Introduction

Senate File 525 (SF 525) laid out a plan to redesign Iowa's mental health and disability services (MHDS). The plan calls for the development of services that implement the principles of Olmstead so that Iowans with disabilities, no matter where they reside, can live safe, healthy, successful, productive, self-determined lives in their homes and communities. To achieve this goal, more than 100 Iowans served on six Redesign Workgroups, comprised of consumers, family members, service providers, professionals, advocates, central point of coordination (CPCs), and boards of supervisors. Workgroup members studied the current system, learned about best practices and made recommendations on what needs to be changed and why.

The Department of Human Services (Department) appreciates the hard work of the Workgroups whose recommendations were positive, thoughtful and informed. **The Department endorses nearly all of the workgroups' recommendations identified in the *Iowa Mental Health and Disability Services Redesign Interim Report*.** This final report includes the Department's recommendations related to areas where there was ambiguity or differences of opinion in the interim report. This report also includes the Department's recommendations for phasing in and financing the recommendations.

The Legislature, through SF 525, directed that the Redesign of the MHDS system must assure:

- Equitable access to a uniform and integrated array of core services;
- Services are based on best practices and be cost effective; and
- Services meet the goals of Olmstead and support Iowans with disabilities to achieve the quality of life they desire in their communities.

The Legislation includes several key policy criteria related to structure, financing and services:

- Establish regional entities to replace the current 99 county administrative structure;
- Expand state funding to directly pay the full non-federal share of Medicaid funded services;
- Using residency in place of legal settlement as a basis for determining financial responsibility; and
- Establish a set of core services reasonably available to all Iowans who need them.

Accomplishing the Legislature's goals demands significant change on the part of the state, counties, providers, consumers, and families. Because the future is unknown and change is hard, understandable resistance has and will continue to occur. While we must build upon the strengths in Iowa's current services, if our problems and shortcomings are not addressed, services will continue to be provided in an inconsistent and inequitable manner and Iowa's MHDS consumers will not be able to fully achieve their potential. History has taught us that minor tweaks will not work.

The individual and collective work of the Redesign Workgroups identified compelling and necessary reasons for major change:

- Iowa does not have an MHDS "system." Current law allows 99 systems to be administered by individual counties — each based on its own values, resources and capabilities. If you do not have a system, you cannot have system reform.
- There is no single point of authority or accountability. Nobody "owns" the system or can be held accountable for achieving positive outcomes in people's lives.
- There are significant gaps, especially for alternatives to more costly, highly used institutional services.
- Service availability as well as service scope are often too much or too little resulting in persons being over-served or under-served.
- Overall, the MHDS workforce is not adequate in number and too often workers do not have the necessary skills or competencies to meet people's needs.

At the request of consumers, families and advocates, the Department conducted a consumer satisfaction survey to determine whether consumers and families believe the system "works." Based on the nearly 1,600 responses, the need for change is evident:

- 56 percent of consumers and families reported they agree or strongly agree that the recommendations contained in the interim report are moving us in the right direction.
- 40 percent of mental health consumers and families reported they are dissatisfied or very dissatisfied with the current MHDS system.
- 27 percent of intellectual disability consumers and families reported they are dissatisfied or very dissatisfied with the current MHDS system.
- 20 percent are undecided about their satisfaction with the services system. Many of those who are "undecided" cited lack of knowledge about the current system and others felt that while the system is difficult to navigate, once services were received, they were somewhat satisfied.

Addressing these reasons for change requires much more than simply adding money to the "system."

These changes must be done thoughtfully, respectfully and methodically while assuring current services are not disrupted. These changes must be based on Olmstead principles that assure persons with disabilities live successful, safe lives in their community, and must build upon the accomplishments of the present services and structures. Finally, the changes must be financially achievable.

A commitment to reform means moving toward best practice service models; implementing priority services that are not currently available in the system or not available statewide; and aligning service funding with desired service outcomes.
With this in mind, this report addresses:

- The Department's recommendations related to areas of ambiguity or differences of opinion in the workgroups' reports;
- Identifies a proposed implementation timeline;

- Provides a cost impact for the Redesign implementation; and
- Identifies a financing strategy for moving ahead.

The workgroup recommendations fall into the following three areas:

- Management/Structure;
- Services; and
- Financing.

MANAGEMENT/STRUCTURE

Regional Administration

Establishing regional entities is one of the more controversial proposals in the Redesign. As envisioned in SF 525:

- The Department will set the standards and assess for accountability;
- The Region will manage and administer non-Medicaid services and coordinate with the Department on Medicaid services; and
- Services, service access and service coordination will continue to be provided at the local level.

The state will have performance-based contracts with between 5 to 15 Regional MHDS administrative entities. The Regions perform administrative functions such as service planning, budgeting for core services, contracting with and paying local providers for non-Medicaid services, and selecting case management providers. Regions are the platform for structuring, financing and implementing the new expanded services and assuring accessibility of services to eligible consumers. They have an important role in coordinating service access and delivery across age groups, disability populations, multiple systems, and funding streams.

Because most of these core administrative functions are carried out by CPCs, a challenge for the Regional Workgroup was to envision how the individual counties could come together in an effective relationship and yet retain individual accountability to the taxpayers. As charged, the Regional Workgroup provided recommendations on options or suggestions for how the regional entities could and should work.

Unless otherwise noted, the Department supports recommendations proposed by the Regional Workgroup. The following addresses comments and concerns raised about the implementation of regional entities.

1. The Regional Workgroup identified that most administrative functions carried out by CPCs today will be consolidated and carried out by the Regions in the future. Regions will ultimately determine appropriate administrative staffing. While some of these functions may be carried out by one individual, other functions such as local point of access and service navigation for consumers and families will require more than one individual to carry out. Therefore it is very possible for some, if not all, of the current CPCs to retain a role in the new regional structure.

2. The Regional Workgroup identified administrative functions of a Region and functions that could be centralized. There are concerns that this will not save funds. However, the Department believes that if done effectively, these consolidations will result in modest cost savings that could be reinvested into direct services. The amount of savings is difficult to forecast and depends on the number of Regions and the number of "backroom" functions that can be centralized such as a centralized 24-hour crisis call center that rolls to the Region.

   In FY 2010, counties expended as much as $22M for all direct and purchased administrative functions. This does not include "in-kind" services such as those provided by the county auditor, county attorney, the outside audit, and support costs.

   The Department recommends that there be a definition of what is included in the legislatively proposed 5 percent administrative cap. Depending on the definition as well as what the 5 percent is based on, 5 percent may not be enough to perform all of the necessary administrative functions.

3. The Regional Workgroup discussed the concerns related to counties pooling their funds. The Department believes that there are adequate strategies to address this concern so that boards of supervisors may be confident that county levied funds are expended for individual county residents (i.e., "virtual" pooling whereby county funds are not actually intermingled).

4. The Regional Workgroup was clear that direct services, points of service access and case management will be provided locally throughout the Region. Establishing a Regional administrative entity will not change this.

5. The Department concurs with the Regional Workgroup recommendation that the regional population size should be targeted to between 200,000 to 700,000, and waivers be granted by the Department only when meeting these parameters is clearly not workable.

6. The Regional Workgroup recommended that each Region be governed by a board comprised of county supervisors (or their designees). Each regional board should also be comprised of at least three consumer and/or family members. While there was consensus that providers should have an active role in advising Regions in service systems planning, there was no consensus as to whether providers should be on the Regions' boards.

   The Department recommends that decisions related to use of tax dollars be made solely by elected officials, but flexibility be provided to the Regions to allow consumer/family and provider involvement in other decisions such as service development.

7. There were several different definitions of residency suggested by the workgroups and no single recommendation. All groups agreed legal settlement must be eliminated and that disputes over payment must not interfere with appropriate, timely service access or delivery.

   When the State becomes responsible for the Medicaid program, the number of individuals whose service funding is based on residency will be significantly reduced.

   The Department supports the Regional Workgroup's definition of residency for persons who are not covered by Medicaid and would add the following clarifications:
   - The Region where the person resides is financially responsible for the cost of non-Medicaid funded core services; and
   - Where a person resides is where the person has an ongoing presence with the declared, good faith intention of remaining for an indefinite period. For persons who are homeless, residency means where they usually sleep.

   The Department recommends any disputes in residency be resolved using the existing dispute resolution process for legal settlement in Iowa Code §225C.8.

   The Department recommends that consumers may appeal regional entities' decisions regarding eligibility for services, level of service or type of service provided. Appeals will be resolved through the Department's existing appeal process using the Department of Inspections and Appeals administrative law judges. The final decision will be made by the director of the Iowa Department of Human Services. Each Region must also be required to have a grievance process through which other disputes will be resolved.

8. The legislation proposes that the Regions be established and operational by July 1, 2013. The Regional Workgroup established the following milestones to accomplish this goal:
   - January 2012 through June 30, 2013 – Regions voluntarily form;
   - January 2012 through 2013 – The Department works with counties and nascent Regions to assist with Regional formation;
   - July 1, 2013 – All Regions meet "formation" criteria; and
   - July 1, 2014 – All Regions meet "implementation" criteria.

   The Department recommends the following, slightly more accelerated, timeline:
   - January 2012 Regions begin to voluntarily form and at this time technical assistance will be available for those requesting it;
   - November 2012 DHS ensures all counties are part of a Region;
   - January 2013 All Regions are formed and begin to organize;
   - June 2013 Regions meet formation criteria; and
   - June 2014 Regions meet implementation criteria.

9. The Regional Workgroup did not clearly identify how the Regions should establish fee for service reimbursement rates for Non-Medicaid funded services.

   The Department recommends that all Regions be required to use the same uniform cost reporting and rate setting process.

SERVICES

Eligibility

The Department supports the following Workgroup recommendations regarding eligibility for adult mental health services:

- Be a resident of Iowa;
- Be 18 and have had at any time during the past year a diagnosable mental, behavioral or emotional disorder that meets the diagnostic criteria specified within the DSM-IV with the exception of the "V" codes, substance abuse disorders and developmental disabilities, unless they co-occur with another diagnosable mental illness; and
- Eligibility for individualized services will be determined by standardized functional assessment tools.

The Department recommends adopting the workgroup recommendation for eligibility for adult mental health services above and adding dementia and antisocial personality disorder to the exceptions unless these conditions co-occur with another diagnosable mental illness. The rationale for these exceptions is that these conditions are not readily responsive to mental health treatment. How payment for dementia and related involuntary commitments would be made needs to be further explored.

The Department supports the recommendation that it continue to explore the implications of expanding the Home and Community Based Services Waiver for persons with intellectual disabilities to include persons with a developmental disability.

The Department recommends the following assessment tools be utilized beginning July 1, 2012:

- Supports Intensity Scale (SIS) for persons with intellectual disabilities;
- LOCUS for persons with chronic mental illness; and
- Uniform Brain Injury assessment process and tool.

The Department recommends the expansion of income eligibility from 150 percent of Federal Poverty Level (FPL) to 200 percent of FPL be re-examined after January 2014 when the Affordable Care Act (ACA) is implemented.

The Department recommends that providers of non-Medicaid services be allowed to waive co-payments if the provider is able to fully absorb the cost.

Outcome and Performance Measures

The workgroups agreed to the following:

- Performance measures are integral to the success and accountability of the service system;
- Outcome and performance measures must be established and tied to individual and family outcomes;
- Provider performance data must be reported directly to the state and then shared with the Regions and providers;
- Performance data should be aggregate and public; and
- A Performance Measures Workgroup must be established to further this work.

The Department concurs that accountability for the use of significant amount of taxpayer funds must be demonstrated by rigorous and meaningful consumer-centered quality of life performance outcome measures. Because of this, the Department will begin publishing preliminary performance outcome measures using currently available data by the end of FY 2012.

The Department recommends that all data be submitted directly to the Department, whereupon the data will be shared with the Regions, providers, Legislature, and public.

The Department recommends establishing a Performance Measures Workgroup comprised of individuals experienced and skilled in data collection, outcome measurement and quality improvement and able to translate the needs of consumers, family members, providers, and funders into practical recommendations. The workgroup will develop a set of performance and outcome "dashboard" indicators that are finalized into a standardized performance and measures outcome tool.

The Department will convene the Service System Data and Statistical Information Integration Workgroup required in SF 525 that involves, at a minimum, Iowa State Association of Counties, the Department and Iowa Department of Public Health, in January 2012.

Workforce Development

The Mental Health, Intellectual/Developmental Disabilities (ID-DD) and Brain Injury Workgroups identified the key need to address workforce shortages and current workforce management practices. In response to these identified needs:

The Department recommends the Legislature establish a MHDS Workforce Development Workgroup composed of workforce experts, consumers and family members in July 2012 to develop a report highlighting key strategies to address workforce shortages to be presented in time for the 2013 Legislative session.

The Department recommends the following improved workforce practices be undertaken statewide:

- Expand the use of peer provided services;
- Increase and improve peer service training including supporting the Peer Support Academy that provides leadership training for peers who provide consumer services; and
- Expand the use of the nationally recognized College of Direct Supports that provides online training for ID-DD and mental health Direct Support Professionals and supervisors in a proven, competency based and cost effective manner.

FINANCING

The Department has developed a five year financial roadmap designed to preserve current services as well as to support an incremental, affordable and logical expansion of new critical core services. The roadmap is specifically designed to simultaneously offer an immediate solution to the concern about the potential significant reductions to non-Medicaid services and non-Medicaid consumers and to begin the transition process.

Key elements include:

- State pays all of the non-federal share of Medicaid services currently paid by counties;
- Continued use of $122.6M regardless of source—property tax or state funding—for non-Medicaid services;
- Recognition of growth of Medicaid and non-Medicaid services;
- Phased implementation of new critical core services; and
- Use of strategies to offset the impact of new costs.

Strategy to Preserve Current Services: State assumes cost of all non-federal share of Medicaid Services

SF 525 proposes that the State assume the cost of the non-federal share of Medicaid services effective July 1, 2013. The Department recommends that this begin July 1, 2012 if there is available funding.

To implement this strategy starting July 1, 2012 would require the Legislature to:

- Redirect the $171M in General Funds that currently goes to the counties to the State Medicaid appropriation;
- Add $47.4M to the Medicaid appropriation;
- Direct the Department to use $12.3M in Social Services Block Grant (SSBG) for the State Payment Program;
- Direct counties to continue to levy local property tax dollars as in FY 2012 to be used to fund non-Medicaid services and populations; and

- Provide assurance to counties and subsequently Regions that they are not financially responsible for individuals on Medicaid waiting lists. The Department would recommend updating Iowa Code Chapter 222 to address this concern.

This strategy assumes:

- Counties first use all of the state General Fund money to pay for the non-federal share of Medicaid services and then use property tax if necessary; and
- Ongoing growth for both Medicaid and non-Medicaid services.

The benefits of this specific strategy include:

- Makes available $135M in FY 2013 for non-Medicaid services thereby eliminating significant reductions of services that will occur if the amount available for non-Medicaid services drops to $87.6M as currently projected;
- Enables the State to begin to implement strategies to assure consistent authorizations for Medicaid services;
- Supports the immediate alignment of Medicaid community-based and institutional services under the single Iowa Medicaid Enterprise (IME) management structure;
- Aligns the non-Medicaid services under the counties and subsequently the Regions as envisioned by the Legislature in SF 525; and
- Does not require the state buy out of county property tax; however, if funds are sufficient and the Legislature so chooses, the plan can easily accommodate a buyout of property tax.

Strategy to Implement New Core Services: Incremental addition of new state funding

Based on consultation with Technical Assistance Collaborative (TAC), review of literature and review of current expenditures, the Department has created estimated projections and funding mix for the addition of new core services.

It is important to note that the financial estimates are based on preliminary information available at this time and are not considered firm estimates. There are many factors and influences that will change as Redesign is further considered and implemented. The estimates do not include offsets that are likely to occur when the action step is fully implemented such as reduced inpatient psychiatric treatment costs when crisis services are fully and effectively implemented. Finally, some of the estimated costs can be partially funded by Medicaid.

Strategy to Implement Offsets to New Funding Need

The Department has identified two major strategies to offset the new funding need. There will very likely be additional savings as a result of the phase-in of new services and new emphasis in management; however, as noted above there are no dollar savings identified with these efforts. The proposed strategies include:

- Participation in the Medicaid Balancing Incentive Program.

- This would allow Iowa to receive a 2 percent increase in federal funding for certain Medicaid programs. To receive these funds, Iowa must commit to having: a single point of entry to institutional services, conflict free case management, standardized assessments, and balance expenditures between institutional and community-based services.
- As a result of implementing the requirements of the Medicaid Balancing Incentive Program persons will move from institutional settings, which are traditionally more expensive, to the community where services will be less expensive.

- If/when ACA is in effect, there will be insurance coverage for persons currently uninsured who would otherwise receive non-Medicaid funded services. This will result in savings and will enable Regions to redirect into expanded new core services thus impacting the need for state funds.

FY 2013-FY 2017 Estimated New Costs

Assuming the savings identified in the three key offset strategies as well as the estimates and assumptions for current services including annual growth as well as the phasing-in of new core services, the overall increased impact to the General Fund is:

	PROPOSED STATE GENERAL FUND INCREASE (In Millions)				
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Cumulative Increase	$42.3	$68.8	$100.5	$121.2	$133.0
Year to Year Increase	$42.3	$26.5	$31.7	$20.7	$11.8

The Department has three other recommendations regarding financing:

- The Department should review and recommend what a sufficient funding level for non-Medicaid services and services to non-Medicaid eligible persons should be;
- State funds used for Department contracts with Regions should:
  - Be targeted in total or in part for services for new core services;
  - Have a portion targeted to Regions who are resource poor to build up their service capacity; and
- Regions should be directed to use any new additional state funding and savings from administrative savings on best and evidenced based practices.

The Department's financial roadmap does not include funding to address waiting lists because it is beyond the scope of SF 525.

Summary of Funding for Phased-In Implementation of Mental Health Redesign

Preserving the Existing Services	With no changes FY 2013	Estimated Fiscal Impact of State Funding of All Medicaid				
		FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Medicaid Expenditures						
State General Funds Sent to the Counties - Assume state funds matched 1st	$171,252,825	$0	$0	$0	$0	$0
Shift all General Funds to IME Medicaid Appropriation	$0	$183,622,307	$183,622,307	$183,622,307	$183,622,307	$183,622,307
Buy out of the counties' share of non-federal portion of Medicaid	$0	$47,415,871	$47,415,871	$47,415,871	$47,415,871	$47,415,871
Estimated 3% Growth in Increased Costs of Medicaid all State Funded	$0	$0	$6,931,145	$14,208,848	$21,850,436	$29,874,103
County Taxes To Fund Medicaid	$59,785,353	$0	$0	$0	$0	$0
Total Non-federal share	$231,038,178	$231,038,178	$237,969,323	$245,247,026	$252,888,614	$260,912,281
Non-Medicaid Expenditures						
Social Services Block Grant (Covers SPP in FY 2013 Proposed)	$12,381,763	$12,381,763	$12,381,763	$12,381,763	$12,381,763	$12,381,763
State Payment Program	$12,369,482	$0	$0	$0	$0	$0
County Taxes	$62,812,315	$62,812,315	$62,812,315	$62,812,315	$62,812,315	$62,812,315
Shift of County Non-federal Share of Medicaid	$0	$59,785,353	$59,785,353	$59,785,353	$59,785,353	$59,785,353
Estimated 3% Growth in Increased Costs of Non-Medicaid all State Funded			$4,049,383	$8,220,247	$12,516,238	$16,941,108
Total Non-Medicaid	$87,563,560	$134,979,431	$139,028,814	$143,199,678	$147,495,669	$151,920,539
TOTAL	$318,601,738	$366,017,609	$376,998,137	$388,446,704	$400,384,282	$412,832,820
TOTAL GENERAL FUND INCREASE TO TRANSITION TO STATE FUNDING OF MEDICAID		**$47,415,871**	**$58,396,399**	**$69,844,966**	**$81,782,544**	**$94,231,082**

Estimated General Fund Impact of Phased-In Plan (In Millions)

	Estimated Fiscal Impact of Phased-In Plan				
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Technical Assistance awarded to Regions by DHS	$0.5	$0.0	$0.0	$0.0	$0.0
Cost of Health Homes for Out Of State (OOS) Children appropriated to IME	$0.5	$0.9	$2.3	$3.6	$3.6
Implementation of Standard Assessments Appropriated to DHS/IME	$3.0	$3.0	$3.0	$3.0	$3.0
Crisis Services					
IME for the non-federal share of Medicaid		$3.4	$6.9	$6.9	$6.9
Regions to cover non-Medicaid costs		$10.1	$20.2	$20.2	$20.2
Sub-acute Services					
IME for the non-federal share of Medicaid		$1.1	$2.3	$2.3	$2.3
Regions to cover non-Medicaid costs		$2.8	$5.7	$5.7	$5.7
Peer Self-Help Drop In Centers appropriated to the Regions		$1.2	$1.2	$1.2	$1.2
Increased and improved employment services appropriated to DHS		$2.0	$2.0	$2.0	$2.0
Institute Positive Behavior Support Statewide					
IME for the non-federal share of Medicaid		$0.5	$0.9	$0.9	$0.9
Regions to cover non-Medicaid costs		$0.4	$0.8	$0.8	$0.8
Health Homes for All Medicaid Eligible Persons with ID & Chronic Mental Illness (CMI) to IME		$0.8	$3.0	$6.0	$6.0
Expand Peer Support Services					
IME for the non-federal share of Medicaid		$0.4	$0.7	$0.7	$0.7
Regions to cover non-Medicaid costs		$0.3	$1.8	$1.8	$1.8
Increase Availability of Post Acute Neurorehabilitation for BI to IME		$2.4	$2.4	$2.4	$2.4
Establish Assertive Community Treatment (ACT) in every Region					
IME for the non-federal share of Medicaid		$0.0	$1.1	$3.5	$3.5
Regions to cover non-Medicaid costs		$0.0	$0.9	$2.9	$2.9
Increased Cost of Transportation Related to Commitment					
IME for the non-federal share of Medicaid		$0.0	$0.2	$0.2	$0.2
Regions to cover non-Medicaid costs		$0.0	$0.4	$0.4	$0.4
Cost of Completing Pre-Commitment Screenings					
IME for the non-federal share of Medicaid		$0.0	$0.2	$0.2	$0.2
Regions to cover non-Medicaid costs		$0.0	$0.6	$0.6	$0.6
Added DHS Staff &Increased Administration Costs	$0.9	$0.9	$0.9	$0.9	$0.9
TOTAL INCREASE FROM FY 2013 APPROVED FOR NEW CRITICAL CORE SERVICES	**$4.9**	**$30.2**	**$57.5**	**$66.2**	**$66.2**

Possible Sources of Funding for Proposed Redesign Costs (In Millions)

Possible Sources of Funding for Proposed Redesign Costs (In Millions)	Estimated Amounts from Savings Initiatives				
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Increased Costs for State Medicaid & New Core Services	$52.3	$88.6	$127.3	$148.0	$160.4
Net Short Term Savings from Balancing Incentive Program to increase FMAP	($10.0)	($7.0)	($1.2)		
Estimated Savings in Services from Balancing Initiative		($1.2)	($2.4)	($3.6)	($4.8)
Estimated Savings from the Affordable Care Act		($11.6)	($23.2)	($23.2)	($22.6)
Total Savings	**($10.0)**	**($19.8)**	**($26.8)**	**($26.8)**	**($27.4)**
TOTAL NET INCREASE FROM FY 2013 APPROVED (In Millions)	**$42.3**	**$68.8**	**$100.5**	**$121.2**	**$133.0**

Redesign Phase-In Plan

As discussed in the section above proposing a financial roadmap, the Department is recommending the following phased approach for activities and service financing. The roadmap is designed to assure a thoughtful and viable phasing-in of the structure, services and finances. Implementing this plan will require Legislative action.

Structure:

- The Department will be responsible for and authorized to carry out activities that support the transition plan including support for the development of Regions, reporting of performance outcome measures and support of the development and delivery of services; and
- The timeframe for the establishment of Regions will provide adequate time for counties to make decisions regarding regional formation and its operational and governance structure by July 1, 2013.

Services:

- Standardized assessment tools will be implemented to support the process of managing a State administered Medicaid program;
- Service financing, aligned with Olmsted principles, best practices and the workgroup recommendations, will be phased-in. Recommended services are those that are most critical in meeting key gaps, cost effective and have been proven to meet consumer and family outcomes. This proposed phase-in will avoid disruption of current services and preserve service stability for consumers; and
- The Department will work with the Iowa Department of Public Health, providers, etc. to coordinate and streamline accreditation and certification processes to the extent allowable by Iowa Code. Should this process identify necessary changes to Iowa Code, recommendations will be forwarded to the 2013 Legislature.

Financing:

- Implementation of uniform cost reporting for Medicaid and non-Medicaid services will minimize duplication of effort and afford providers, Medicaid and the Regions greater predictability for planning and budgeting purposes;
- State financing strategies as noted in the prior section will provide greater predictability and stability of funding of non-Medicaid services and populations; and
- State financing strategies will take advantage of available federal Medicaid opportunities to refocus and enhance current Medicaid options.

Table 1: Proposed Transition Phase-In

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016/2017
MANAGEMENT/ STRUCTURE					
DHS	DHS meets with counties and IDPH Data Workgroup and develops proposal for data collection DHS convenes Performance Measures Workgroup and DHS publishes performance measures using existing data DHS publishes administrative rules for Regions DHS submits State Medicaid Plan amendments DHS meets with IDPH and others to streamline accreditation standards	DHS implements data collection DHS implements performance measurement plan and publishes data DHS contracts for technical assistance (TA) for Regions DHS provides TA support to Regions	DHS begins data collection from Regions DHS publishes performance data DHS enters into performance-based contracts with Regions including development of new critical core services	DHS continues data collection from Regions DHS publishes performance data DHS enters into performance-based contracts with Regions including development of new critical core services	DHS continues data collection from Regions DHS publishes performance data DHS enters into performance-based contracts with Regions including development of new critical core services
Regions	Counties may begin to form Regions Counties budget for FY 13 services	Counties finalize Regions & DHS addresses those that have not formed Regions receive TA Regions contract with DHS by June 30	Regions operational Regions do key strategic planning and begin to implement new core services	Regions operational and expand core services	Regions operational and expand core services

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016/2017
NEW CORE SERVICE PHASE					
MHDS Services Adult & Children/Youth		Implement Screening Tools Health Homes for Children/Youth Begin to bring out of state children/youth home	Continue and expand services funded in FY 13 And Add: • Crisis Services • Sub Acute Services • Peer Self Help Drop In Centers • Increased Employment Services • Positive Behavior Support statewide • Expand Peer Provided Services • Health Homes for all Medicaid eligible ID and CMI persons • Expand Post Acute Neurorehabilitation for Brain Injury	Continue and expand services funded in FY 14 And Add: • Increase ACT use • Cost of Transportation for commitments • Pre-Commitment Screening	Continue and expand services funded in FY 14
FINANCING					
Counties	Counties certify FY 13 budget	Based on funding decisions counties may certify FY 14 budget	Based on funding decisions counties may certify FY 15 budget	Based on funding decisions counties may certify FY 16 budget	Based on funding decisions counties may certify FY 17 budget
Financing	DHS submits roadmap DHS applies for the CMS "Balancing Incentive Payment Program" to access additional federal financial participation	DHS submits FY 14 budget DHS issues and awards RFP for out of state children/youth to return home DHS implements balancing program	DHS submits FY 15 budget DHS implements balancing program State implementation of ACA	DHS submits FY 16 budget DHS implements balancing program State implementation of ACA	DHS submits FY 17 budget State implementation of ACA

Next Steps

As the Legislature implements legislation to support the execution of Redesign, the Department will continue to provide analysis and support to address key questions.

Success in achieving the vision established by the Legislature requires open, consistent and transparent communication. The Department is committed to continuing to meet with key constituency groups including consumers, families, counties, and providers to hear their observations, concerns and recommendations regarding MHDS Redesign. This critical information will be used to help steer the course of Redesign.

As the Redesign process continues, the Department will maintain its Redesign website and include key updates and announcements:
http://www.dhs.state.ia.us/Partners/MHDSRedesign.html.

Appendix

Appendix 1: MHDS Transition Plan Cost Estimates (Pages 21-22)

	Cost Estimate When Fully Implemented in FY 2017 (In Millions)			
Action Step	**Total**	**Federal**	**State Match to Medicaid**	**State Funds for Non-Medicaid**
Medicaid Buyout: Buyout the counties' non-federal share of Medicaid freeing current county tax funds to be used for non-Medicaid funded services.	$47.4	$0	$47.4	$0
Estimated 3 percent growth in Medicaid & Non-Medicaid Services	$91.4	$44.6	$29.9	$16.9
Technical Assistance for Regional Management: This one time funding would allow Regions to secure Technical Assistance from outside resources in addition to support provided by DHS staff.	$0.5	$0	$0.5	$0
Out of State Children (OOS): Issue an RFP for children/youth served out of Iowa. Most of the costs of serving these children/youth would come from savings from not paying OOS providers. Establishment of Health Homes for children/youth with a SED would be a critical part of this initiative. Establishing Health Homes would require coverage of all children/youth who qualify. However, the Affordable Care Act provides 90 percent federal matching funds for the first two years the program is in effect. It is estimated that by the end of two years the Medicaid cost savings generated by Health Homes will cover the cost of the service.	$9	$5.4	$3.6	$0
Implement Standardized Assessments: • SIS – Completed by independent assessors. • LOCUS – Completed by clinicians and TCM's. Includes the cost of instrument and staff time. • Brain Injury – Completed by independent assessors.	$5.7	$2.7	$1.8	$1.2
Establish Crisis Services in Each Region. Crisis Services include: • A centralized 24-Hour Crisis Hotline • Crisis Mobile Response • Crisis for persons with ID-DD (i.e., IPART) • Emergency Walk In • 23-hour Crisis Observation • Crisis Residential (3 beds per region) • Jail Diversion including support for local law enforcement training for Crisis Intervention Teams (CIT) and mental health first aid • Training and Technical Assistance	$37.1	$10	$6.9	$20.2
Sub-Acute Services: Establish Sub-Acute Services in each Region. Short-term psychiatric services provide the consumer experiencing a mental health crisis with services and supports in a safe, secure setting that is person and family centered, recovery oriented and developmentally appropriate.	$11.4	$3.4	$2.3	$5.7

	Cost Estimate When Fully Implemented in FY 2017 (In Millions)			
Action Step	**Total**	**Federal**	**State Match to Medicaid**	**State Funds for Non-Medicaid**
Peer Self-Help Drop In Centers. This funding provides for $120,000 for 10 consumer governed/operated drop-in and support centers around the state.	$1.2	$0	$0	$1.2
Implement Increased and Improved Employment Services: Integrated, competitive employment is a valued activity by many MHDS consumers. This added funding will assist providers with supporting consumers who choose integrated, competitive employment as their valued day activity.	$4	$2	$2	$0
Positive Behavior Support: Establish the use of positive behavior support as standard evidenced based practice throughout the state.	$3	$1.3	$0.9	$0.8
Health Homes: Establish health homes for persons with severe and persistent mental illness or intellectual disabilities eligible for Medicaid to ensure coordination of disability treatment and physical health care. (Estimate includes assumed saving from other Medicaid Services.)	$15	$9	$6	$0
Peer Support: Increase the use of peer support as a widely available service for persons with a severe and persistent mental illness or intellectual disability statewide.	$3.5	$1	$0.7	$1.8
Post-Acute Neurorehabilitation: Increase availability across the service continuum to reduce the need for out of state placement and increase ability to bring people back to Iowa.	$6	$3.6	$2.4	$0
Increase the use of Assertive Community Treatment (ACT). ACT has been shown to be a proven effective evidenced based practice that supports persons with severe and persistent mental illness successfully in their home and community. This proposal triples the number of ACT sites.	$11.6	$5.2	$3.5	$2.9
Transportation for Commitments: Provide transportation related to commitments as a core service statewide.	$0.9	$0.3	$0.2	$0.4
Pre-commitment Screenings: Provide opportunities for pre-commitment screenings statewide to ensure commitment proceedings are necessary.	$1.2	$0.4	$0.2	$0.6
DHS Staff will be responsible for collection and reporting of outcome measures and oversee Medicaid service utilization.	$0.9	$0	$0.9	$0