Overview

Financing of Iowa's Adult Mental Health and Disability Services

SFY2009 Data

Thursday, August 19, 2010
Presented By Jeanne Nesbit
Created by Julie Jetter and Robyn Wilson 1

PURPOSE:

- Identify funding sources for adults with
  - Mental Illness
  - Intellectual/Developmental Disabilities
  - Brain Injury
- Identify Services
- Identify Methods of Service Planning by funding source
- Opportunities for Improvement

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State Mandated Service Array

- Involuntary Commitment Services
  - Evaluation/Hospital Costs
  - Sheriff's Transportation
  - Attorney Fee's related to Commitment
  - Judicial Advocate Fees
- Voluntary Inpatient at the Mental Health Institutes

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County Plan Service Array
$334,896,052 /approx. 55,000 people

Services Funded by Counties	Dollars Spent	Persons Served
Personal and Environmental Support Services	30.79%	21.45%
Licensed/Certified Living Arrangements	26.90%	5.09%
Vocational and Day Services	13.93%	13.44%
Institutional/Hospital and Commitment Services	10.19%	12.85%
Psychotherapeutic Treatment	9.95%	31.90%
Coordination Services	6.89%	15.28%
Administrative	1.31%	
Information and Education Services	0.04%	
Total	100.00%	100.00%

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Residential Services for Persons with Developmental Disabilities:

Status and Trends Through 2009

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This report is also available at http://rtc.umn.edu/risp09

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Table 2.5 Persons with ID/DD on a Waiting List for, But Not Receiving Residential Services on June 30, 2009

State	Total Persons on Waiting List	Total Residential Service Recipients	% Growth Required to Match Needs
AL	1,159	3,549	32.7
AK	981 [e]	1,062	92.4
AZ	67	4,111	1.6
AR	874	3,863	22.6
CA	0	55,436	0.0
CO	1,135	5,227	21.7
CT	482	7,001	6.9
DE	169	1,028	16.4
DC	0	1,280	0.0
FL	3,780 [e]	15,339	24.6
GA	1,626	5,961	27.3
HI	0	1,114	0.0
ID	0	4,373	0.0
IL	12,289	21,311	57.7
IN	17,382	9,257	187.8
IA	27	8,994	0.3
KS	1,287	5,761	22.3
KY	363	4,097	8.9
LA	DNF	7,332	DNF
ME	73	2,910	2.5
MD	18,698	7,438	251.4
MA	0	12,235	0.0
MI	45 [e]	14,607	0.3
MN	2,853	14,157	20.2
MS	DNF	3,379	DNF
MO	531	6,511	8.2
MT	598	1,893	31.6
NE	2,059	3,013	68.3
NV	352	1,544	22.8
NH	208	1,795	11.6
NJ	DNF	13,389	DNF
NM	4,610	2,158	213.6
NY	4,409	46,568	9.5
NC	DNF	10,013	DNF
ND	0	2,062	0.0
OH	DNF	22,521	DNF
OK	4,885	4,404	110.9
OR	3,399 [e]	5,664	60.0
PA	2,095	24,015	8.7
RI	0	2,237	0.0
SC	2,022	4,885	41.4
SD	0	2,307	0.0
TN	856	5,355	16.0
TX	DNF	25,640	DNF
UT	1,924	3,303	58.3
VT	0	1,554	0.0
VA	4,306	7,411	58.1
WA	DNF	7,168	DNF
WV	154	1,947	7.9
WI	4,057	11,341	35.8
WY	115	1,271	9.0
Reporting States	99,870	357,241	28.0
Estimated US Total	122,870	439,515	28.0

[e] = estimate

Note: Estimates from non reporting states based on the ratio of persons waiting to persons served in the reporting states

2010

MONTHLY SLOT & WAITING LIST DATA**

Definitions	
Waiver Cap that has been approved by CMS	The amount of slots allowed by CMS
Waiver funding cap	The amount of slots allowed by how much funding we have for the slots.
Consumers currently Approved on ISIS	The number of slots Approved (being utilized) in ISIS
Slots Pending Approval Date	The number of slots that have been given to a consumer but have not yet been approved in ISIS.
Slots Temporarily Closed	The number of slots that have been given but not reassigned due to holding the slot for the consumer for a certain amount of time
Waiver Waiting List	The number of consumers that are waiting for a slot
Application date of next Consumer to receive a slot	The oldest application date on the waiting list. (the next consumer to receive a slot will have the oldest application date per each waiver)
**NUMBERS LISTED REPRESENT PRIOR MONTH'S ELIGIBILITY STATS	

	1-10	2-10	3-10	4-10	5-10	6-10	7-10	8-10	9-10	10-10	11-10	12-10
AIDS/HIV												
AIDS/HIV Cap that has been approved by CMS	165	165	165	165	165	165	165	165	165	165	165	165
AIDS/HIV waiver funding cap	56	56	56	56	56	56	56	56	56	56	56	56
Consumers currently Approved on ISIS	47	49	48	49	46	46	43	44	45	44	43	41
Slots Pending Approval Date	6	7	7	5	4	5	9	9	9	10	10	12
Slots Temporarily Closed	3	0	1	2	6	5	4	3	2	2	3	2
AIDS/HIV Waiting List	18	16	18	18	19	18	12	10	12	8	12	10
Application date of next Consumer to receive a slot	6/11/09	7/16/09	9/14/09	9/28/09	10/13/09	10/28/09	2/11/10	2/18/10	3/1/10	5/25/10	8/5/10	8/24/10
BRAIN INJURY												
BI Cap that has been approved by CMS	1261	1261	1261	1261	1261	1261	1261	1261	1261	1261	1261	1261
BI waiver funding cap	1168	1168	1168	1168	1168	1168	1168	1168	1168	1168	1168	1168
Consumers Currently Approved on ISIS	1075	1063	1061	1067	1061	1053	1058	1054	1054	1061	1079	1078
Slots Pending Approval Date	70	75	84	77	85	105	95	261	276	293	218	191
Slots Temporarily Closed	21	27	28	26	24	13	16	24	25	7	26	43
BI Waiting List	818	835	830	846	857	855	864	695	653	586	618	634
BI Applicants since 1996	4008	4050	4071	4114	4154	4190	4221	4268	4298	4339	4389	4410
Application date of next Consumer to receive a slot	6/4/08	6/25/08	7/18/08	8/5/08	8/27/08	9/24/08	10/10/08	3/4/09	4/21/09	6/30/09	7/17/09	7/28/09

2010

MONTHLY SLOT & WAITING LIST DATA**

	1-10	2-10	3-10	4-10	5-10	6-10	7-10	8-10	9-10	10-10	11-10	12-10
BI Slots for ICF/MR, NF, OOS												
BI Slots Cap for ICF/MR, NF, OOS	5	5	5	5	5	5	5	15	15	15	15	15
BI OOS Consumers Currently Approved	0	0	2	1	3	3	3	3	3	0	0	0
Slots Pending Approval Date	4	4	4	4	2	1	1	3	4	1	3	3
Slots Temporarily Closed	0	0	0	1	1	3	3	2	0	0	0	0
Slots Closed	1	1	1	1	1	1	2	5	4	0	0	0
BI ICF/MR, NF, OOS Waiting List	1	1	1	1	1	1	1	1	0	0	0	0
CMH WAIVER												
CMH Funding slots cap	1117	1117	1117	1117	1117	1117	1117	1117	1117	1117	1117	1117
CMH Consumers Currently Approved on ISIS	641	658	679	701	714	702	685	670	663	662	670	634
Slots Pending Approval	192	155	127	63	26	17	63	134	175	168	253	197
Slots Temporarily Closed	57	61	45	40	25	30	26	27	17	29	29	37
CMH Waiting List	425	423	436	509	608	676	691	650	643	660	577	622
Application date of next Consumer to receive a slot	4/29/09	5/29/09	6/17/09	2/18/09	2/18/09	2/18/09	7/14/09	9/1/09	10/5/09	11/10/09	2/12/10	2/12/10
CMH Reserved Capacity Slots												
CMH Reserved Capacity Slots Cap							10	10	10	10	10	10
CMH Reserved Capacity Slots Currently Approved on ISIS							0	0	2	4	5	6
CMH Reserved Capacity Slots Pending Approval Date							0	4	8	6	5	4
CMH Reserved Capacity Slots Temporarily Closed							0	0	0	0	0	0
CMH Reserved Capacity Slots Closed							0	0	0	0	0	0
CMH Reserved Capacity Slots Waiting List							0	0	0	1	1	1
Application date of next Consumer to receive a slot										9/20/10	9/20/10	9/20/10
ELDERLY												
Elderly funding Cap	12052	12052	12052	12052	12052	12052	12052	12052	12052	12052	12052	12052
Consumers currently approved on ISIS	9718	9630	9562	9570	9615	9592	9545	9478	9406	9376	9339	9293

Updated on 12/2/2010

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MONTHLY SLOT & WAITING LIST DATA**

	1-10	2-10	3-10	4-10	5-10	6-10	7-10	8-10	9-10	10-10	11-10	12-10
INTELLECTUAL DISABILITY												
ID Children Slots Cap that has been approved by CMS	2848	2848	2848	2848	2848	2848	2848	2848	2848	2848	2848	2848
ID Child waiver funding cap	2851	2851	2851	2851	2851	2851	2851	2851	2851	2851	2851	2851
ID Children Currently Approved	2563	2572	2572	2608	2597	2609	2551	2530	2510	2523	2517	2509
ID Children Slots Pending Approval	290	281	286	290	285	268	298	306	314	301	294	328
ID Children Temporarily Closed	19	11	16	3	18	26	13	27	36	36	51	24
ID Children Waiting List	0	0	0	18	55	63	68	56	65	65	77	52
Application date of next Consumer to receive a slot	-	-	-	3/18/10	4/9/10	4/26/10	6/4/10	6/29/10	7/22/10	7/2/10	9/22/10	7/2/10
Res-Based SCL Slots Cap that has been approved by CMS	72	72	72	72	72	72	72	72	72	72	72	72
Res-Based SCL Consumers Served Currently	36	35	31	33	33	33	36	34	35	33	35	31
Res-Based SCL Consumers Pending Approval	6	9	9	4	3	3	6	7	3	4	2	4
Res-Based SCL Consumers Temporarily Closed	4	4	4	2	1	1	2	3	2	2	4	4
Res-Based SCL Slots waiting list	0	0	0	0	0	0	0	0	0	0	0	0
ID Adult State Case Slots Cap that has been approved by CMS	343	343	343	343	343	343	343	343	343	343	343	343
ID Adult State Case waiver funding cap	472	472	472	472	472	572	572	572	572	572	572	572
ID Adult State Cases Served Currently	524	522	518	547	546	538	538	460	533	535	531	534
ID Adult State Case Slots Pending Approval	16	19	17	4	6	8	7	20	29	37	34	29
ID Adult State Case Slots Temporarily Closed	6	3	8	6	5	8	8	2	1	3	3	5
ID Adult State Case Waiting List	67	67	67	73	84	90	94	90	89	75	87	93
Application date of next Consumer to receive a slot	10/16/07	10/16/07	10/16/07	10/16/07	10/16/07	10/16/07	10/16/07	3/11/09	4/21/09	6/24/09	6/24/09	6/24/09
ID MFP/ICF/MR Slots Cap	100	100	100	100	100	100	100	100	100	100	100	100
MR ICF/MR Waiting List	0	0	0	0	0	0	0	0	0	0	0	0
Total-Children & Adults Approved on ISIS	10671	10707	10713	10736	10768	10803	10840	10883	10876	10934	10941	10958

Updated on 12/2/2010

2010
MONTHLY SLOT & WAITING LIST DATA**

	1-10	2-10	3-10	4-10	5-10	6-10	7-10	8-10	9-10	10-10	11-10	12-10
ILL & HANDICAPPED												
I&H Cap that has been approved by CMS	3309	3309	3309	3309	3309	3309	3309	3309	3309	3309	3309	3309
IH waiver funding cap	3163	3163	3163	3163	3163	3163	3163	3163	3163	3163	3163	3163
I&H Consumers Currently Approved on ISIS	2503	2514	2495	2466	2484	2483	2470	2457	2427	2429	2418	2405
Slots Pending Approval	234	218	234	242	222	218	227	343	461	531	544	499
Slots Temporarily Closed	71	69	85	98	103	96	101	140	147	182	113	122
I&H Waiting List	1996	2043	2038	2044	2090	2096	2097	2001	1880	1761	1705	1716
Application date of next Consumer to receive a slot	8/27/08	9/15/08	10/7/08	10/30/08	11/21/08	12/15/08	1/15/09	3/4/09	4/22/09	6/24/09	8/12/09	8/25/09
PHYSICAL DISABILITY												
PD Cap that has been approved by CMS	1644	1444	1444	1444	1444	1444	1444	1644	1644	1644	1644	1644
PD waiver funding cap	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
Consumers currently Approved on ISIS	838	830	828	843	836	838	837	824	827	818	841	840
Slots Pending Approval Date	117	129	146	131	116	114	104	303	345	442	330	326
Slots Temporarily Closed	24	22	22	26	43	43	57	5	13	41	77	67
PD Waiting List	1594	1629	1634	1661	1716	1757	1793	1621	1575	1449	1539	1533
Application date of next Consumer to receive a slot	8/18/08	9/8/08	9/26/08	10/15/08	10/27/08	11/10/08	11/24/08	3/4/09	4/16/09	6/24/09	7/9/09	7/28/09
TOTAL Waiver Consumers Approved through ISIS	25493	25451	25386	25432	25524	25517	25478	25410	25298	25324	25331	25292
TOTAL Consumers on all waiver waiting lists	4918	5013	5023	5169	5329	5555	5619	5123	4917	4604	4615	4660

	1-10	2-10	3-10	4-10	5-10	6-10	7-10	8-10	9-10	10-10	11-10	12-10
Habilitation Services												
Habilitation Services Cap	4079	4079	4079	4079	4079	4079	4079	4079	4079	4079	4079	4079
Consumers currently Approved on ISIS	3270	3342	3295	3362	3439	3411	3443	3578	3617	3577	3584	3555
Slots Pending Approval Date	147	170	173	222	221	205	187	197	210	195	208	208
Slots Temporarily Closed	119	87	92	57	32	85	115	42	50	70	115	159
Waiting List	0	0	0	0	0	0	0	0	0	0	0	0
Remedial Services												
Consumers currently Approved on ISIS	10570	11455	11310	12189	12398	12244	12198	12569	12693	12055	11970	11875

Updated on 12/2/2010

Wood, Craig

From: Wood, Craig
Sent: Tuesday, January 18, 2011 11:35 AM
To: 'lioinfo@legis.state.ia.us'
Subject: Testimony

Regarding HF45 (Previously HSB1), Public Hearing scheduled January 18, 2011.

Re: Section 130, County Waiting Lists

The Allowable Growth appropriation to counties for Mental Health and Disabilities Services was reduced by $21 Million during the across the board cuts of FY2009 and FY2010, which were carried forward into FY2011. The $25 Million appropriated here restores those cuts, but limits access to those counties that have established a waiting list. I am a little nervous about leaving it up to the Risk Pool Board to decide the process for distributing the money, but having this appropriation is better than a kick in the pants, which is what we have gotten for the last 3 years.

Re: Section 131, Service System Reform

p.47, line 9 ("lack a set of core services…") This is inaccurate. There IS a set of core services uniformly available throughout the state. Most counties EXCEEED the required set, which accounts for variances in the array of services in some areas. The state has the power to increase the required set of core services at any time, but doing so has not been a funding priority for the Legislature.

p.47, lines 11-14 (lack uniformity in expenditures and levy rates). Agreed, these are issues. The issue was caused by freezing counties levies at a point in time (1996); so whatever disparity existed at that time remains in effect. In addition the State funds allocated to counties is primarily based on county MHDD expenditures at that point in time, and that helps to maintain the disparities.

p.47, line 15. Agreed, there is a need to improve the array of services. This will cost money. You can bring equity to the system in two ways: take Linn County's array down to the level of counties that only do the minimum, or bring counties with a smaller array up to the level of Linn County. To bring it up will cost money. To let it slide down will save money but not IMPROVE anything other than to bring equity to the system.

p.47, line 18. Agreed, there is a need to expand dual diagnosis services. Again, it is not free.

p.47, line 20. Agreed, there is a need to improve consistency of services. Again, it is not free.

p.47, line 22 (Preparing for PPACA). Most people with Mental Retardation and chronic mental illness who access Medicaid services that are matched by county dollars are already on Medicaid. I don't see this as causing a huge increase in cost, though there will be some increase. I think PPACA will BENEFIT the current system by removing the need for counties to pay for inpatient and outpatient psychiatric services. I would agree that there is much to do to address PPACA, but I'm not so sure that reforming the mental health system needs to be one of the major areas of focus. Doing the things we are doing with Iowa Code 230A and the Mental Health Center rules seem to me to be more important as far as the Mental Health piece of PPACA.

p.47, line 27 (Dissatisfaction with legal settlement). I haven't heard

consumer groups talk about this since we changed the law and required counties of legal settlement to cover the costs of services authorized by the county of residence. The main problem these days has to do with court commitments and who pays the hospitals because inpatient services are provided by a few large hospitals serving multiple counties now that many smaller hospitals have closed psychiatric units. And the county solution to that is to make commitments and court costs state responsibility, which would eliminate the need for courts and hospitals to worry about legal settlement. This could be funded by reducing the Allowable Growth appropriation by the amount that counties currently pay for court commitments to state institutions and local hospitals (after first restoring Allowable Growth to its pre-recession level).

p.47, line 35-p.48, line 3 (Assuming non-federal share of Medicaid costs). If the State can afford to do this at the same time as taking over funding the court system, fine. The county position is that it makes more sense, if there is a phase in, to start with the commitment system. The reasoning is that the courts and state institutions are more logically managed by the state since they are state operated programs. On the other hand, Medicaid waiver services are community based, locally accessed, and more logically locally managed; and the providers are smaller, private entities, with relationships developed with local county personnel. It does make sense in the long run for the State to assume payment of the non-federal share for all Medicaid services; and it would increase efficiency if the state did not have to bill counties for the non-federal share of those services, and if the counties did not have to process payment of those bills. It would be pretty expensive to do that ($155 Million in FY2009). Some of that funding could come from Allowable Growth, but only a small part. There is only $48.6 Million in Allowable Growth, and it is $20 million short of where it needs to be to make up for the huge FMAP decrease coming up. Taking over court commitment expenses is only $34 Million. Senator Hatch has a bill out there that proposes taking back Property Tax Relief in order to do cover the cost of the Medicaid match, but I don't think the Republican Caucus wants to reduce Property Tax Relief.

p.48, line 4 (State assuming a greater role in funding). I lobbied pretty hard for this concept back in 1995, when the current system was being developed, and I'm sorry I did. I don't think services for people with disabilities will ever be a State funding priority. These services will usually take a back seat to education, public safety (prisons), and even roads. So when the State budget is in trouble, they cut our services first. I could certainly agree that these services ought to be income tax based rather than property tax based, if we had some sort of guarantee that the core set of services would be funded and that the core set of services were the Linn County set as opposed to the minimum set. My experience, however, tells me that consumers were better off when they could deal with county boards of supervisors to get what they needed. There were disparities, but the disparities were due to pockets of excellence, not due to counties not covering the services the state requires them to cover.

p.48, line 9 (implementing a new service system). I'm not sure of the objective in this section. As indicated above, the State can "ensure greater uniformity" by requiring all counties to provide the Linn County array. The State has not done that because it will cost money. There is no evidence that I am aware of that size has anything to do with "developing effective services". Some small counties have quite effective services, while some large counties do not. It has more to do with funding and the disparities in existence at the time of the freeze. Size could impact the ability to finance services if we had a system of allocating state funds based on a case rate, which would require a certain number of "covered eligibles" in order to be able to manage the allocation properly. Counties proposed that concept back in 1999. But that is not being proposed in this bill. If the thinking is that regionalization will create a sufficient efficiency to finance all of the improvements discussed above, i.e. increasing the set of core services state wide, it will not. There might be a slight savings, but

not nearly the millions of dollars it would take to accomplish those objectives. Many smaller counties already share a CPC, and other smaller counties have a CPC who doubles as General Relief Director and sometimes has additional county duties. So it is not as if there is a full time CPC in every county that will go away if regions are created. One of the goals of the MHDS Commission has been to improve access to services for consumers, and shutting down local offices, as DHS has done in its cost-savings efforts, does not improve access. In terms of planning and having counties in a region offer similar arrays and similar processes, most counties have already joined together in regional planning groups to accomplish that, and there is statewide participation via ISAC to bring consistency to data management and reporting, contracting, and rate-setting.

In sum, while I appreciate the goal of this bill to improve funding of essential services and increase the array of services to all Iowans with disabilities, I am not sure that this bill in its present form will accomplish that. In order to "improve effectiveness", "expand the array of services", and "ensure greater uniformity", there will need to be a commitment to invest money in the system. The system is NOT broken, it is simply broke, and needs more money. Without it, "greater uniformity" will occur by default, because all counties will be driven to providing only the minimum level of services required by the State. I am certain that counties would be happy to participate in the work of the committees assigned to address these issues.

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Matrix for County Funded Services

SERVICE	MI	CMI	ID	DD	BI
4x03 Information and Referral					
4x04 Consultation.					
4x05 Public Education Services					
4x06 Academic Services.					
4x11 Direct Administrative.	X	X	X	X	
4x12 Purchased Administrative					
4x21- 374 Case Management- Medicaid Match.		X	X	X	
4x21- 375 Case Management -100% County Funded					
4x21- 399 Other.					
4x22 Services Management.					
4x31 Transportation (Non-Sheriff).			X		
4x32- 320 Homemaker/Home Health Aides					
4x32- 321 Chore Services					
4x32- 322 Home Management Services			X		
4x32- 325 Respite.			X		
4x32- 326 Guardian/Conservator.					
4x32- 327 Representative Payee					
4x32- 328 Home/Vehicle Modification			X		
4x32- 329 Supported Community Living		X	X		
4x32- 399 Other.					
4x33- 345 Ongoing Rent Subsidy.					
4x33- 399 Other					
4x41- 305 Outpatient					
4x41- 306 Prescription Medication.					
4x41- 307 In-Home Nursing					
4x41- 399 Other					
4x42- 305 Outpatient	X	X	X	X	
4x42- 309 Partial Hospitalization.		X			
4x42- 399 Other.					
4x43- Evaluation.					
4x44- 363 Day Treatment Services		X			
4x44- 396 Community Support Programs					
4x44- 397 Psychiatric Rehabilitation					
4x44- 399 Other					
4x50- 360 Sheltered Workshop Services.					
4x50- 362 Work Activity Services		X	X		
4x50- 364 Job Placement Services.			X		
4x50- 367 Adult Day Care.		X	X		
4x50- 368 Supported Employment Services		X	X		
4x50- 369 Enclave			X		
4x50- 399 Other.					
4x63- 310 Community Supervised Apartment Living Arrangement (CSALA) 1-5 Beds					
4x63- 314 Residential Care Facility (RCF License) 1-5 Beds		X	X		
4x63- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 1-5 Beds			X		
4x63- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 1-5 Beds		X			
4x63- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 1-5 Beds					
4x63- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License) 1-5 Beds			X	X	
4x63- 329 Supported Community Living		X	X		
4x63- 399 Other 1-5 Beds.					
4x64- 310 Community Supervised Apartment Living Arrangement (CSALA) 6-15 Beds					
4x64- 314 Residential Care Facility (RCF License) 6-15 Beds		X	X		
4x64- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 6-15 Beds			X		
4x64- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 6-15 Beds		X			
4x64- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 6-15 Beds					
4x64- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License) 6-15 Beds			X	X	
4x64- 399 Other 6-15 Beds..					
4x65- 310 Community Supervised Apartment Living Arrangement (CSALA) 16 and over Beds					
4x65- 314 Residential Care Facility (RCF License) 16 and over Beds		X	X		
4x65- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 16 and over Beds			X		
4x65- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 16 and over Beds		X			
4x65- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 16 and over Beds					

4x65- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License)			X	X	
4x65- 399 Other 16 and over Beds..					
4x71- 319 Inpatient/State Mental Health Institutes	X	X	X	X	
4x71- 399 Other					
4x72- 319 Inpatient/State Hospital Schools			X	X	
4x72- 399 Other.					
4x73- 319 Inpatient/Community Hospital					
4x73- 399 Other					
4x74- 300 Diagnostic Evaluations Related To Commitment.	X	X	X	X	
4x74- 353 Sheriff Transportation	X	X	X	X	
4x74- 393 Legal Representation for Commitment	X	X	X	X	
4x74- 395 Mental Health Advocates	X	X	X	X	
4x74- 399 Other					

SERVICES AND SUPPORTS THAT LINN COUNTY WILL FUND

SERVICE	MI	CMI	MR	DD	BI
4x03 Information and Referral				X	
4x04 Consultation.	X	X	X	X	
4x05 Public Education Services					
4x06 Academic Services.	X	X	X	X	
4x11 Direct Administrative.	X	X	X	X	
4x12 Purchased Administrative					
4x21- 374 Case Management- Medicaid Match.		X	X	X	X
4x21- 375 Case Management -100% County Funded	X	X	X	X	
4x21- 399 Other.		X	X	X	
4x22 Services Management.	X	X	X	X	
4x31 Transportation (Non-Sheriff).	X	X	X	X	
4x32- 320 Homemaker/Home Health Aides.	X	X	X	X	
4x32- 321 Chore Services	X	X	X	X	
4x32- 322 Home Management Services	X	X	X	X	
4x32- 325 Respite.	X	X	X	X	
4x32- 326 Guardian/Conservator.	X	X	X	X	
4x32- 327 Representative Payee	X	X	X	X	
4x32- 328 Home/Vehicle Modification			X		
4x32- 329 Supported Community Living	X	X	X	X	
4x32- 399 Other.					
4x33- 345 Ongoing Rent Subsidy.	X	X	X	X	
4x33- 399 Other					
4x41- 305 Outpatient	X	X	X	X	
4x41- 306 Prescription Medication.	X	X	X	X	
4x41- 307 In-Home Nursing			X		
4x41- 399 Other					
4x42- 305 Outpatient	X	X	X	X	
4x42- 309 Partial Hospitalization.	X	X	X	X	
4x42- 399 Other.					
4x43- Evaluation.	X	X	X	X	
4x44- 363 Day Treatment Services	X	X	X	X	
4x44- 396 Community Support Programs	X	X	X	X	
4x44- 397 Psychiatric Rehabilitation		X			
4x44- 399 Other					
4x50- 360 Sheltered Workshop Services.	X	X	X	X	
4x50- 362 Work Activity Services		X	X	X	
4x50- 364 Job Placement Services.	X	X	X	X	
4x50- 367 Adult Day Care.	X	X	X	X	
4x50- 368 Supported Employment Services	X	X	X	X	
4x50- 369 Enclave	X	X	X	X	

4x50- 399 Other.					
4x63- 310 Community Supervised Apartment Living Arrangement (CSALA) 1-5 Beds		X	X	X	
4x63- 314 Residential Care Facility (RCF License) 1-5 Beds		X	X	X	
4x63- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 1-5 Beds		X	X	X	
4x63- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 1-5 Beds		X	X	X	
4x63- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 1-5 Beds		X	X	X	
4x63- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License) 1-5 Beds			X	X	
4x63- 329 Supported Community Living		X	X	X	
4x63- 399 Other 1-5 Beds.		X	X	X	
4x64- 310 Community Supervised Apartment Living Arrangement (CSALA) 6-15 Beds		X	X	X	
4x64- 314 Residential Care Facility (RCF License) 6-15 Beds		X	X	X	
4x64- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 6-15 Beds			X	X	
4x64- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 6-15 Beds		X			
4x64- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 6-15 Beds		X	X	X	
4x64- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License) 6-15 Beds			X	X	
4x64- 399 Other 6-15 Beds..					
4x65- 310 Community Supervised Apartment Living Arrangement (CSALA) 16 and over Beds					
4x65- 314 Residential Care Facility (RCF License) 16 and over Beds		X	X	X	
4x65- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 16 and over Beds			X	X	
4x65- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 16 and over Beds		X	X	X	
4x65- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 16 and over Beds		X	X	X	
4x65- 318 Intermediate Care Facility For The Mentally Retarded (ICF/MR License)			X	X	
4x65- 399 Other 16 and over Beds..					
4x71- 319 Inpatient/State Mental Health Institutes	X	X	X	X	
4x71- 399 Other	X	X	X	X	
4x72- 319 Inpatient/State Hospital Schools			X	X	
4x72- 399 Other.					
4x73- 319 Inpatient/Community Hospital	X	X	X	X	
4x73- 399 Other	X	X	X	X	
4x74- 300 Diagnostic Evaluations Related To Commitment.	X	X	X	X	
4x74- 353 Sheriff Transportation	X	X	X	X	
4x74- 393 Legal Representation for Commitment	X	X	X	X	
4x74- 395 Mental Health Advocates	X	X	X	X	
4x74- 399 Other					

If, as indicated in page 1, line 30, "significant new funding will be needed to pay the match" for the newly eligibles, the state will need new funding as well as the counties. However, it is my understanding that the newly eligibles will be covered by the feds for two years.

The main group of "newly eligibles" will be people with mental illness not currently classified as disabled, but who will be eligible based on the 133% of poverty income guidelines, and those are people we currently pay 100% for at the mental health centers and hospitals. The Affordable Care Act will SAVE us money by covering people with Medicaid dollars that we currently cover, and that's a savings of approximately $30 Million statewide.

I don't envision a lot of "newly eligibles" among the group for whom we currently pay the match. People that access those services generally meet the current guidelines for Medicaid, and people who will be among the "newly eligibles" don't generally access those services (i.e. ICFMR, ID Waiver, and Habilitation Services). So I don't see the Affordable Care Act being a big strain on county budgets, but I do see it as being a savings.

The notion described in page 2, line 8, of combining Substance Abuse and Mental Health under one agency, is an idea that the State's national expert consultant with whom they contract (i.e. Ken Minkoff) has said is NOT a good idea as a starting point. He has seen difficulties arise when other states have done that. I have discussed it with him in my role as a MHDS Commission member, because we were looking at such a combination as a possible legislative position. He believes developing co-occurring capabilities statewide ought to follow a different path and have different priorities, possibly ending with the combining of the two state agencies.

Page 2, lines 11-23 are confusing to me. I'm not sure you can have "many common elements" but not a "basic set of services". "Many common elements" IS a "basic set of services" it seems to me, even if the set of services is not as broad as we would want. I'd also like to know what the "many public services available to young people" are that are not available to adults. I'm not aware of what those would be outside of educational services. The Children's mental health waiver has a larger waitng list than the county managed ID Waiver, and children on the ID Waiver are automatically granted a slot in the Adult ID waiver system. Children are being forced into the county financed court commitment process because they can't get services any other way.

Page 2, line 28-30 says if you have a size of 300,000, services magically become more uniform; and I'm not sure how that happens just by increasing the geographical area served by a management entity, without investing additional dollars into the system.

Page 3, lines 5 -18 are also confusing to me. First it says shift all of the money currently allocated to counties, then it says shift $40 Million of Allowable Growth.

Page 3, lines 12-14, says to provide property tax relief but also talks about equalizing levies, which for some counties could be an increase in the MHDD levy. I suppose if the state assumes more responsibility, the levies could be equalized by reducing all of the higher levied counties.

Page 3, System Redesign. At least counties will be at the table. I think counties should bring up our 1999 Restructuring Proposal again, which talks about a case rate (which would require a regional base from which to manage the cases in order to be able to spread the money over a specified number of "covered eligibles". As I recall, our national technical consultants advised against a capitated rate based on population due to the variance in penetration rates from one region to another. Our proposal also contained a "core set of services" that would have to be available uniformly, it did away with legal settlement, and it simplified and brought equity to state appropriation and county expenditures (all objectives of HF45). Of course, that proposal required an increased investment on the part of the State, which is where it got bogged down. As some of you old people may recall, we had sign off on that proposal by state provider organizations and consumer groups, and it still was not approved. It was all about the money. Maybe we should just throw it out there and say, "What's wrong with that?"

Page 5, lines 7-12 are the services that the ISAC Legislative Objective recommends to be assumed by the state, as opposed to the Medicaid match. I suppose that is really an uphill battle for the counties. There seems to be a real desire on the part of IME to do the match that we currently do. Maybe what we should do is to say to them to take the Medicaid match AND the state institutions, commitments, etc., and we will use our property tax dollars to do our innovative stuff that Medicaid and other insurers will not cover, such as Jail Diversion, Mobile Crisis, Vocational (non-Medicaid), and Residential (non-Medicaid), transportation, etc. Along with that they should lift the caps on the MHDD levy so that counties can fund any disability services the local constituents can convince the property taxpayers to cover. They were pretty good at that in the past. The only problem with that is that then some counties would have services that other counties didn't, and we'd have that disparity thing again.

Page 5, lines 16 and 17, does recommend a regional structure "that maintains county and other local investment" whatever that means.

Page 5, line 26 again mentions the 300,000 minimum population for a region. I wonder where they came up with that number. Is there some research out there? There might be. I just haven't seen it.

Senate Study Bill 1077 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON RAGAN)

A BILL FOR

An Act relating to reforming state and county responsibilities for adult mental health, mental retardation, and developmental disabilities services and providing effective dates.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

TLSB 1422XC (2) 84
jp/rj

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Section 1. FINDINGS AND PURPOSE.

1. The general assembly finds that full implementation of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, in 2014 will have a significant impact on services to low-income Iowans because eligibility for the Medicaid program will be simplified to include individuals having an income at or below 133 percent of the federal poverty level. Consequently, the additional categorical eligibility requirements now applicable for Medicaid program eligibility, such as being a recipient of federal supplemental security income (SSI) or for meeting Medicaid program waiver requirements, will no longer apply. Because Medicaid is such a significant funding source for Iowa's state-county mental health, mental retardation, and developmental disabilities system for adults, the simplified eligibility change presents an opportunity to reform that system. The simplified Medicaid eligibility provisions coming into force in 2014 also will provide Medicaid eligibility to many adults whose services costs are wholly or primarily a county responsibility.

2. Under current law, counties pay the nonfederal share of the costs of Medicaid program services provided to address the needs of eligible adults with mental illness or mental retardation and some counties voluntarily pay for Medicaid program service costs to address developmental disabilities in addition to mental retardation. Because the increases in overall funding for such services have experienced very limited growth in recent years, the annual increases needed to fund the county Medicaid responsibility have been reducing the funding counties have available to fund other non-Medicaid services. With the federal expansion in those eligible for the Medicaid program, significant new funding will be needed to provide the match for the new eligible adults.

3. It is the intent of the general assembly to incrementally shift responsibility for the funding of Medicaid services for adults with mental illness or mental retardation from the

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counties to the state so that the shift is completed by 2014 when the new federal law takes effect.

4. Among adults who have a serious mental illness, the incidence of those with a co-occurring disorder involving abuse of alcohol or another substance is much higher than among the population without such an illness. However, the availability of treatment that simultaneously addresses both disorders is very limited. This situation could be helped by assigning responsibility for both types of treatment to one state agency instead of two, as is currently the case.

5. a. Under current law, if an adult has serious mental illness or mental retardation and does not have a means of paying for services, the primary responsibility to fund and make the services available is assigned to counties. Although many common elements do exist among the service arrays offered by counties, a basic set of services is not available in all counties, waiting lists for some services are in effect in some counties, the availability of community-based services in some counties is very limited, and other disparities exist. For example, many publicly funded services available to young persons are not continued when the young persons become adults because public funding of the services does not exist for adults.

b. It is the intent of the general assembly to address such disparity by shifting the responsibility for adult mental illness services from the counties to the state and requiring regional county administration of the services for persons with mental retardation. Regions covering a general population of at least 300,000 would be of sufficient size to make services availability more uniform.

6. a. Counties are limited to levying approximately $125 million in property taxes statewide for the services due to law enacted in the mid-1990s. The state distributes to counties approximately $89 million to replace equivalent reductions in the amount of property taxes raised for this purpose. In

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addition, for fiscal year 2010-2011, the state will distribute to counties approximately $49 million in allowed growth funds, approximately $14 million in community services funds, and approximately $11 million to reimburse for state cases.

b. It is the intent of the general assembly to shift the funding described in paragraph "a" and to provide additional funding as necessary to accomplish the following goals:

(1) State assumption of Medicaid cost-share responsibility currently held by counties.

(2) Improvement in the uniformity and availability of services administered by both the state and counties.

(3) Provision of property tax relief through direct state assumption of responsibility for costs and moving toward levy uniformity.

c. It is the intent of the general assembly to shift $40 million or more of allowed growth funding for fiscal year 2011-2012 for use by the state to assume an equivalent-cost county responsibility for funding of Medicaid program service.

Sec. 2. SERVICE SYSTEM REFORM PLANNING.

1. The department of human services shall consult with stakeholders, including counties and service consumers, providers, and advocates, in proposing a schedule, funding provisions, and other associated actions necessary for the state to incrementally assume the responsibilities of counties for payment of the nonfederal share of Medicaid program services by the date in 2014 when the Medicaid program enhancements under the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, take effect. The department shall submit the plan, accompanied by appropriate findings and recommendations, to the governor and general assembly on or before December 1, 2011.

2. The departments of human services and public health shall consult with stakeholders, including counties and service consumers, providers, and advocates, in developing a plan for the shifting of mental illness services responsibilities

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between the two departments as described in this Act. The target date for implementation shall be July 1, 2012. The departments shall submit the plan, accompanied by appropriate findings and recommendations, to the governor and general assembly on or before December 1, 2011. The plan shall include recommended legislation addressing statutory changes necessary for implementation of the plan and of section 125.99, as enacted by this Act.

3. The department of human services shall consult with stakeholders, including counties and service consumers, providers, and advocates, in proposing a schedule, funding provisions, and other associated actions necessary for the regional administration of adult mental retardation and developmental disabilities services consistent with the legislative intent stated in this Act. The target date for implementation shall be July 1, 2013. The department shall submit the plan, accompanied by appropriate findings and recommendations, to the governor and general assembly on or before December 1, 2012.

Sec. 3. NEW SECTION. **125.99 Mental health and substance abuse treatment authority.**

1. Notwithstanding section 225C.3 or any provision of law to the contrary, effective July 1, 2011, the department is designated as the state's adult mental health and substance abuse services authority.

2. The authority shall do all of the following:

a. Develop a mental health and substance abuse services infrastructure based on a business enterprise model and designed to foster collaboration among all program stakeholders by focusing on quality, integrity, and consistency.

b. Cost-effectively expand the availability of services for those with a single mental illness or substance abuse disorder and those with co-occurring disorders.

c. Form a close, collaborative relationship with the Medicaid enterprise to effectively provide those services that

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are funded by the Medicaid program.

d. Provide leadership to align the other providers and funders of mental illness and substance abuse services into a coherent provider continuum of services, including but not limited to all of the following services:

(1) County-funded transportation and other services.

(2) Hospital services.

(3) Court-ordered services.

(4) Services provided in connection with the justice system.

(5) Services provided in connection with the state's education systems for children and adults.

e. Identify and facilitate the development of a basic set of services and other support to address the needs of adults with mental illness and substance abuse problems.

f. (1) Develop a regional structure that is designed to maintain county and other local investment and involvement in addressing the needs of adults with mental illness and substance abuse problems.

(2) The approaches considered in developing a delivery system for meeting such needs shall include but are not limited to adaptation of the physical health medical home model for use in addressing mental health and substance abuse treatment needs.

(3) The size of regions in the structure shall cover a general population of at least three hundred thousand.

3. The recommendations, plans, implementation provisions, and other actions taken by the authority and the stakeholders working with the authority to implement this section shall be guided by appropriate recognition of best practices, departmental and service provider capacity, the diagnostic criteria for the diseases and other conditions outlined in the current edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association, and the value contributed by mental health and

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substance abuse professionals to the well-being of the citizens of this state.

Sec. 4. EFFECTIVE UPON ENACTMENT. This Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

This bill provides legislative findings, legislative intent, and a planning process to reorganize state and county responsibilities for provision and funding of services for adults with mental illness, mental retardation, and developmental disabilities.

New Code section 125.99 designates the department of public health as the state's mental health and substance abuse services authority for adults with mental illness and substance abuse service needs. Under current law in Code section 225C.3, the division of mental health and disability services of the department of human services is designated as the state mental health authority for federal purposes. Various planning and implementation duties are specified for the department of public health authority. A statement of guiding principles is included. Another section of the bill requires the departments of human services and public health to develop and submit a plan for shifting responsibilities between the two departments.

The bill takes effect upon enactment.

Improvements through Partnerships

A Summary of the Mental Health & Mental Retardation/Developmentally Disabled Service System Plan for Improvements

(For more specific information, please refer to the Central Point of Coordination CPC Restructuring Task Force Report)

What do we need to do !

1. **Increase federal funding for mental health and mental retardation services**: Iowa needs to maximize federal funding for community mental health and mental retardation / developmental disability services. Increased funding for the service system is needed, but it should come from federal funding as much as possible. **See p.48, line5**
2. **Replace the current institution based mandates with a defined set of core community services:** The current mandates need to be replaced with a set of services for eligible consumers with mental illness, mental retardation or a developmental disability. Driven by consumers, families and communities, an array of appropriate services will be more cost effective and reflect the needs of Iowans. Required core services would include inpatient, ICF/MR, residential services, but would also include innovative outpatient, community supports, case management, and habilitative and rehabilitative community services. Creative development of community based supports would be encouraged under this plan. **See p. 47, line 27 and line 33**
3. **Assure equity of access to core services through a funding formula in which state and county dollars are directly linked to consumers**: Currently there is variability among Iowa Counties with regard to the amount of state and county funds available for community mental health and mental retardation / developmental disability services. This new strategy would provide equity of access through a funding formula that links state/federal dollars to actual enrolled consumers; based upon each consumer's disability and level of functioning. **See p. 47, line 29 and line 31**
4. **Develop a community-friendly system by transitioning from the cumbersome process of legal settlement to principles of equitable service access based on residency**: Once core services are available on an equitable basis throughout Iowa, with a funding process which allows dollars to follow consumers wherever they choose to live, it will no longer be necessary to carry out the time-consuming process of establishing legal settlement. A state payment program for individuals for whom no county of legal settlement can be established will no longer be necessary. Access to services will be based on county of residence. **See p. 48, line 10**
5. **Standardize clinical and financial eligibility for defined core mental health and mental retardation / developmental disability services on a statewide basis**: Currently, counties have different financial, clinical and service eligibility requirements for access to services. In addition to general clinical and financial eligibility standards, consistent statewide level of care and service access criteria and protocols will be developed to provide fair, consistent, equitable access. Input from stakeholders would shape the development of standards. Crisis response, disaster response outreach, public education and community consultation would be recognized as necessary to meet the needs of all of Iowa's citizens. **See p. 47, line 27**

6. **Expand the state-operated risk pool, and encourage counties to accrue funds to cover local risk factors**: In agreeing to these system changes, counties are assuming some financial risk. Under a true partnership, that risk should be shared by the counties and by the state. The self-insured portion of the risk, at the county level, should be defined as three months of a county's operating budget. Fund balances should be calculated in conformance with generally accepted accounting principles which allow designation of funds to maintain solvency and allow for strategic planning. The state risk pool should be expanded. Counties facing short-term financial risk because of the funding formula or unusual enrollment rates will be permitted to access the state risk pool.

7. **Redefine the roles of the state and counties in the management of mental health and mental retardation / developmental disability services and enhance the participation of consumers and families in planning, operating, and evaluating mental health and mental retardation services**: It is critical in the system restructuring plan to redefine the roles of key players in Iowa's mental health and mental retardation / developmental disability system. These partners include consumers and families, providers, advocacy groups, the State Department of Human Services, the various state mental health and developmental disability planning and oversight committees, the State-County Management Committee, and County CPC Administrators. This can be accomplished by:

   - Merging the State-County Management Committee and MH/DD Commission at the state level to provide citizen oversight of the system.
   - Redefining the role of the State Department of Human Services to emphasize its responsibilities for policy and standard setting and over-all system evaluation.
   - Redefining the roles and responsibilities of counties to emphasize their functions with regard to local system planning, development, operations, performance and quality management.
   - Establishing equity between community providers and state institutions through net budgeting.

Conclusion: Improvements through partnerships is interactive and interdependent. In addressing issues, the CPC Administrators have focused on the system as a whole; embracing the realization that the involvement of all of Iowa's citizens is necessary for enduring improvements. This recommendation is not a quick fix, but a thoughtful long-term blueprint to begin the process of system evolution. As in any true partnership, there will be challenges. Counties will face challenges - to hold themselves accountable for administering a high quality system of services in a consistent, fair, equitable, and efficient manner. The state, as the primary funder, will be challenged to provide effective leadership through system evaluation and development of standardized practices. Thoughtful input from consumers, family members, providers and advocacy groups must guide the process. All Iowa communities will benefit greatly from this initiative if the state, counties and stakeholders work in unison to make the mental health and mental retardation / developmental disability service system a responsive, fair, and equitable process.

pay the nonfederal share of the costs. The distribution allocations shall be completed on or before July 1, 2011.

c. The general assembly finds that as of the time of enactment of this section, the funding appropriated in this section is sufficient to eliminate the need for continuing , instituting, or reinstituting waiting lists during the period addressed by the appropriation. However, the process implemented by the risk pool board shall ensure there is adequate funding so that a person made eligible for services and other support from the waiting list would not be required to return to the waiting list if a later projection indicates the funding is insufficient to cover for the entire period all individuals removed from the waiting list pursuant to this section.

d. The funding provided in this section is intended to provide necessary services for adults in need of mental health, mental retardation, or developmental disabilities services until improvements to the current system can be developed and enacted.

Sec. 132. ADULT MENTAL HEALTH AND DISABILITY SERVICE SYSTEM REFORM.

1. The general assembly finds there is need to reform the adult mental health and disability services system administered by counties to address the needs of persons with mental illness, mental retardation, or developmental disabilities. Issues with the current system include the following:

a. Lack of a set of core services uniformly available throughout the state.

b. Lack of uniformity in service expenditures throughout the state.

c. Disparity in county levy rates for the services funds for this system.

d. The need to improve the array of community-based services and services to avoid the use or continued use of crisis services.

e. The need to expand the availability of dual diagnosis mental health and substance abuse services.

f. The need to improve the consistency of services available to both youth and adult populations.

g. The need to address the medical assistance (Medicaid) program changes in the federal Patient Protection and Affordable Care Act (PPACA) that will greatly expand the program's eligibility for persons in the service system beginning in calendar year 2014.

h. Dissatisfaction with using county of legal settlement determinations to determine county and state financial responsibility for services.

2. In order to address the issues identified in subsection 1, the committees on human resources, appropriations, and ways and means of the senate and house of representatives shall propose legislation to address the following actions by the dates indicated:

a. Phase-in of the state fully assuming the nonfederal share of the costs for Medicaid program services now borne by counties by the implementation date of the Medicaid eligibility changes under PPACA.

b. Provide property tax relief and equity by having the state assume a greater role in funding the adult mental health and disability services system from counties by July 1, 2012, when the repeals contained in this division of this Act take effect.

c. Shift the balance of responsibilities for the services system between the state and counties so that the state ensures greater uniformity and there is sufficient size to develop effective services while maintaining the county role of bringing local resources together in unique ways that best meet the needs of clients, by implementing a new services system structure by July 1, 2012, when the repeals contained in this division of this Act take effect.

Sec. 133. Section 331.424A, Code 2011, is amended by adding