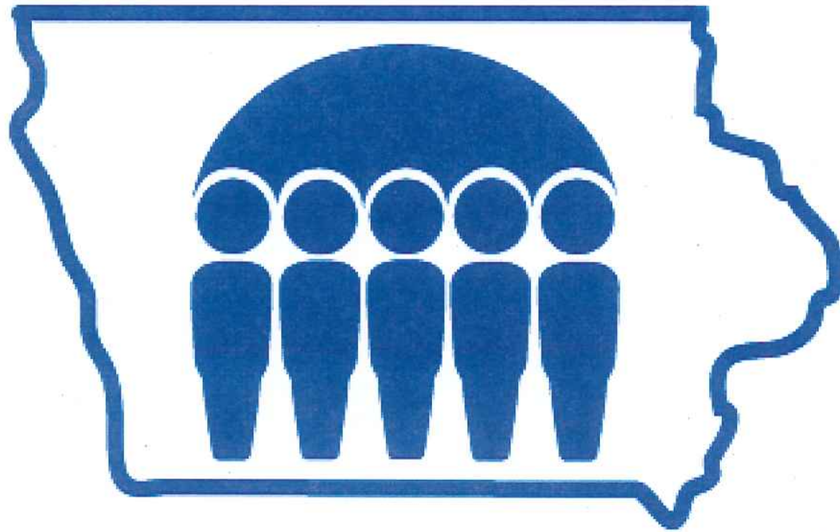
Iowa Department of Human Services



Mental Health and Disabilities Services Redesign

January 2012

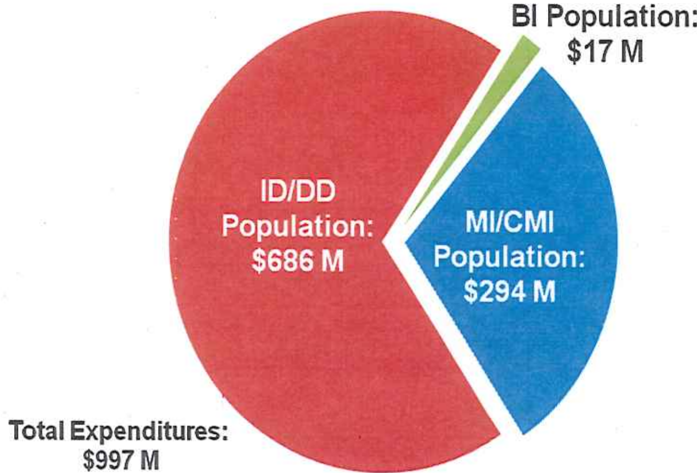
OVERVIEW

Key issues regarding the current Mental Health and Disabilities (MHDS) System:

- 99 counties are authorized to manage services based on their own values, resources and capabilities.
- There is no single point of authority or accountability – Nobody owns the system.
- Services are provided inequitably and inconsistently across the state.
- There are significant service gaps, especially for alternatives to more costly, highly used institutional services.
- MHDS financing is ineffective, inefficient, too complex, and fraught with "transactional friction."

Characteristics of the MHDS System:

- Most MHDS expenditures are for persons with intellectual disabilities and most of those are Medicaid funded.
- The Federal and state government fund the majority of MHDS services.
- Medicaid services are entitlements, so increases in Medicaid costs directly affects the amount of funding available for non-Medicaid services (e.g., housing, vocational and transportation) and non-Medicaid populations - primarily persons with a mental illness.
- If changes are not made, estimates are there will be a $56 million (39%) drop in funding for non-Medicaid Services in FY 2013.



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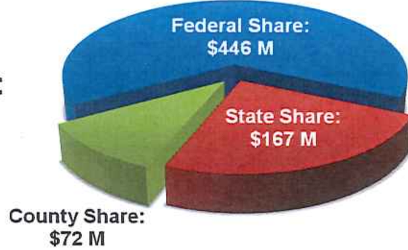
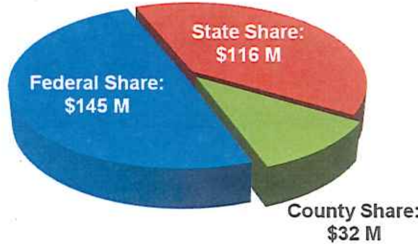
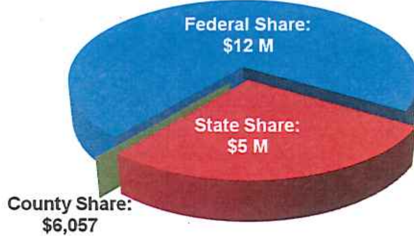
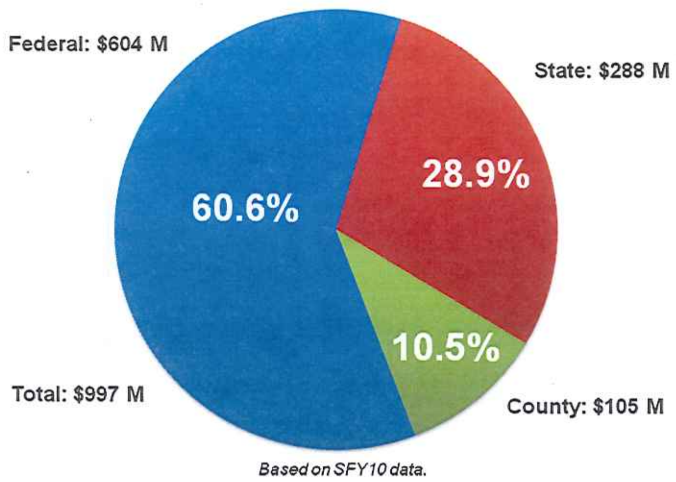






Adult MHDS Funding Sources



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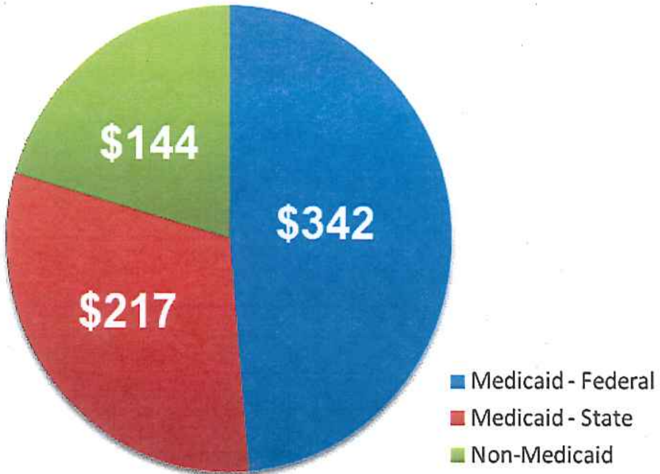
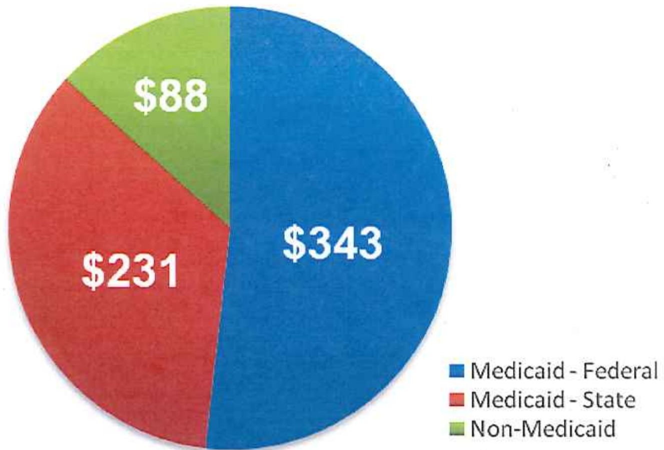
Medicaid and Non-Medicaid Expenditures: Projected Change between FY 2012 and FY 2013





MHDS Redesign

Senate File 525 established a plan to redesign Iowa's MHDS System and address these issues. The Department of Human Services (DHS) was charged with engaging Workgroups to develop recommendations to implement the plan.

DHS did the following to carry out its expectations:

- Hired the Technical Assistance Collaborative (TAC) to facilitate the Workgroups.
- Established 6 Workgroups with over 100 members to develop recommendations.
- Conducted 10 "listening post meetings" attended by over 1,000 people across the state.
- Surveyed over 1,600 MHDS consumers and families:
  - Many voiced dissatisfaction with the current MHDS System; and
  - Most supported the direction of MHDS Redesign.
- Submitted an *Interim Report* of the Workgroups' recommendations on October 31, 2011.
- Submitted a *Final Report* with the Department's recommendations on December 9, 2011 that:
  - Endorsed nearly all of the Workgroups' recommendations; and
  - Provided additional recommendations and clarifications.

The MHDS Legislative Interim Study Committee adopted the Department's *Final Report* with amendments (See Appendix).

The Workgroups' and DHS' recommendations fall into three areas:

- Services – Specifying basic services and new critical core services based on best practice.
- Management/Structure – Addressing clear accountability and locus of responsibility and administrative efficiencies.
- Financing – Addressing the current funding complexities and challenges.

Key Service Recommendations

- All services should be locally provided and available within the Region.
- New critical core services should be phased-in over time within each Region including services that:
  - Bring Iowa children being served out of state back home and prevent future out of state placement;
  - Reduce the use of higher level more costly institutional services:
  - Support persons with complex needs to live more productive, successful community lives; and
  - Support an effective and efficient commitment process.

- DHS should gather and publish outcomes data that measures service effectiveness.
- DHS should implement improved workforce practices and the Legislature should establish a MHDS Workforce Development Workgroup.
- Eligibility
  - Medicaid eligibility should remain the same,
  - DHS should continue to cost out expanding Medicaid waiver funded services to include all persons with a developmental disability,
  - Financial eligibility should remain at 150% of the federal poverty level and be reconsidered when/if the Affordable Care Act is implemented, and
  - Eligibility for Mental Health Services should include persons with mental health diagnosis with some exceptions (i.e. individuals with relationship problems or a sole diagnosis of substance abuse, developmental disability, dementia, or antisocial personality disorder).
- Management of services should include the use of uniform service assessment tools beginning in FY 2013.

KEY MANAGEMENT/STRUCTURE

In the proposed MHDS System structure:

- The State will set the standards.
- The Region will administer services.
- Services will be provided locally.

Regional management was recommended for several reasons including:

- Achieving economies of scale, and reducing duplication of administration and inefficiencies to better use scarce resources.
- Giving rural counties the opportunity to draw on capacities of urban counties.
- Assuring consistent, equitable, simplified access to a full array of core services.
- Providing a clear locus of accountability and responsibility.

Recommendations include:

- There should be between 10 -15 Regions ranging in size from 200,000 to 700,000 in population. DHS should be given authority to waive size requirements when the parameters are not workable.
- Regions should manage and fund non-Medicaid services, establish local points of service access and designate case management.

- Regions should be responsible for paying for non-Medicaid services for persons residing in the Region. Time-based legal settlement should be eliminated.
- Regional Governing Boards should be made up of members of the Boards of Supervisors who make decisions regarding the use of tax funds. Consumers and providers can be involved in other key decisions.
- DHS should award state funds to Regions through outcome oriented performance based contracts.
- Consumers should have access to the DHS appeal process for disagreements regarding eligibility and service decisions. Regions should be required to have an established grievance process for other concerns.
- Regions should use uniform definitions and cost reports for establishing reimbursement rates.
- Regions should form by January 1, 2013 and be operational July 1, 2013. DHS will arrange for technical assistance (i.e., model 28E agreements, job descriptions, accounting tools, etc.).

KEY FINANCING RECOMMENDATIONS

DHS' proposal funds non-Medicaid services close to FY 2012 levels, protects non-Medicaid funding from being eroded by Medicaid growth, greatly simplifies the funding system, phases-in new critical core services, and allows Regions to use administrative savings for services. To achieve this DHS proposes that:

- The State should:
    - Directly pay the full non-federal share of Medicaid currently paid by the counties;
    - Pay for growth in both Medicaid and non-Medicaid services;
    - Phase-in new critical core services over five years using a combination of state general funds, federal Medicaid funds, and Regional savings; and
    - Use strategies such as the Balancing Incentive Program and the Affordable Care Act (ACA), if implemented, to off-set the impact of new costs.
- $122 to $125M should continue to be made available regardless of source – property tax or state funding – for non-Medicaid services.

The FY 2013 cost for this plan is $42 million.

Based on these recommendations:

- Non-Medicaid services will be funded at close to FY 2012 levels.
- MHDS redesign will begin FY 2013.
- Critical core services will begin FY 2014.
- Regional savings will be reinvested as early as FY 2014 into non-Medicaid services.

A summary of the DHS funding plan is as follows:

	Amounts in Millions					
	No Changes	---Proposed---				
	FY 2013	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Medicaid Expenditures	$231	$231	$238	$245	$253	$261
Non-Medicaid Expenditures	$88	$135	$139	$143	$147	$152
Total	$319	$366	$377	$388	$400	$413
Cost of Phased-In Critical Core Services		$5	$30	$58	$66	$66
Annual Savings from Balancing and ACA		-$10	-$20	-$27	-$27	-$27
TOTAL	$319	$361	$387	$419	$440	$452
Net Increase from the Approved FY 2013		$42	$69	$101	$121	$133
Year to Year Increase		$42	$27	$32	$21	$12

Totals may not add due to rounding

Appendix 1: Amendments to the Departments Report

The Mental Health and Disability Services Study Committee passed amendments to the DHS' Plan to be included in the draft bill. A summary of those amendments include:

- There will be a policy bill and a separate appropriations bill.
- DHS will consult with counties/Regions, consumers, family and providers to determine the amount of non-Medicaid funding needed.
- DHS will determine the fiscal impact of eliminating the current waiting lists.
- DHS will examine different ways to manage issues with the waiting lists.
- Each Region must have an advisory committee of consumers, service providers, and regional governing board members.
- The Children's Services Workgroup is charged with submitting a proposal for an integrated children's system involving child welfare, juvenile justice, children's mental health, and education using the health home approach.
- Brain Injury (BI) Workgroup will prioritize its recommendations.
- The Judicial-DHS Workgroup recommendations will be drafted in a separate bill.
- DHS is to develop cost estimates for the recommendations.