MH/MR/DD/BI Commission
Adult Redesign Review
Wednesday 10-3-06

Present: Susan Koch-Seehase, Cindy Kaestner, Richard Heitmann, Jan Heikes, and Julie Jetter

What follows is a summary of a review of the "MHDD Redesign Report 1-23-04" by a group of relatively new Commission members with guidance and input by former Commission member, Julie Jetter. While we attempted to perform a thorough review, there may be activities or elements that we are unaware of. Other commissioners and staff should feel free to note those items and/or corrections and bring to the attention of the committee and Commission as a whole.

SYSTEM VALUES (page 6)

Choice: The ability of Iowans with disabilities and their families to make informed choices about the amounts and types of service and supports received.

Empowerment: The reinforcement of the fundamental rights, dignity and ability of Iowans with disabilities to provide valuable input, accept responsibility, make informed choices, and take risks.

Community: The system supports the right, dignity, and ability of all individuals with disabilities to live, learn, work, and recreate in the communities of their choice.

Committee Findings and Recommendations:

The system values listed are those of choice, empowerment and community. Since submission of this "Redesign Report", there has been an emerging value that services should be based on need rather than choice. Clarification of "Choice" must be made to bring the definition in line with the current practice. The committee suggests "Choice: The ability of Iowans with disabilities and their families to make informed choices about the amounts and types of services and support received based on need."

"Empowerment" is another value, which implies the involvement of consumers and families on committees reporting to the Commission. There has been an under representation of these individuals on committees which may be corrected by insuring that adequate financial reimbursement happens for these valued volunteers.

RECOMMENDATIONS (beginning on page 8)

A. ASSURE UNIVERSAL ACCESS TO INFORMATION, SERVICE COORDINATION AND CRISIS/EMERGENCY SERVICES

The Commission recommends providing information to those who are seeking disability service information and outreach to those who may be unaware of but are in need of disability services.

1. If eligible, the individual must apply for federally funded services and supports.

2. *Individuals should be linked to emergency services without regard to individuals' residency or financial eligibility.*
3. *Service coordination and crisis/ emergency services should be reasonably available locally.*

Committee Findings and Recommendations:

These services are currently required to be part of the counties plans. Since the additions of CPC's and County Management Plans, the access of information, service coordination and crisis/emergency services have greatly improved in the Adult System.

B. ESTABLISH FINANCIAL ELIGIBILITY STANDARDS

The Commission recommends the following minimum financial eligibility, resource limits, and co-pay standards for people accessing disability services funding:

1. *People who have income below 150% of the federal poverty level (FPL) should have services 100% publicly funded.*
2. *People with incomes above 150% FPL may be required to pay a co-pay based on a statewide maximum sliding scale.*
3. *Because utilizing available federal funding is a high priority, individuals may be denied eligibility for county funded services and supports if they choose not to apply for federally funded services and supports.*
4. *Resource limits should be established that are consistent with Social Security resource limits. For persons who do not, or likely will not qualify for federal disability programs, but who otherwise meet the income and functional guidelines for service, the following accounts should be exempt from resource limits:*
    a. *Retirement accounts that are in the accumulation stage*
    b. *Burial accounts*
    c. *Medical savings accounts*
    d. *Assistive technology accounts*

Committee Findings and Recommendations:

The statewide financial eligibility guidelines implemented 7/1/06 is that people who have incomes below 150% of the federal poverty level (FPL) will have 100% publicly funded services.

There is currently a statewide workgroup addressing a standard co-payment schedule for those above 150% of FPL and standardizing resource limits. This has proved to be more difficult than initially believed due to the variety of standards in federal programs, which must be accessed first before county and state funds are used. This workgroup will be drafting rule to be presented to the MH/MR/DD/BI Commission in 2007.

C. ESTABLISH FUNCTIONAL/DIAGNOSTIC ELIGIBILITY STANDARDS

The Commission recommends using the following diagnostic criteria:

1. *The person is diagnosed with mental illness OR*
2. *The person is diagnosed with chronic mental illness OR*
3. *The person is diagnosed with mentally retardation OR*
4. *The person is diagnosed with a development disability OR*
5. *The person has a brain injury as defined in Iowa Administrative Code 441-83.81 AND*
6. *The person achieves a qualifying functional assessment score.*

The Commission recommends adopting, with consumer input, statewide standardized functional assessment tools to be used to establish both system funding eligibility and the level of services and supports that an individual needs. It may be that separate assessment tools and separate processes are the best way to accomplish both these goals.

Iowa Code §229.1 defines "mental illness" and "seriously mentally impaired" for the purpose of involuntary civil commitments. The Commission supports maintaining those definitions for that purpose. However, the Commission supports discontinuing use of "chronic mental illness" as defined in Iowa Administrative Code 441-90.1 as a disability category, and beginning to use "serious mental illness" as defined in Section 1912(c) of the Public Health Services Act as the disability category instead.

Committee Findings and Recommendations:

The Functional Assessment Team consisting of DHS staff, University of Iowa consultants, CPCs, agency staff, and consumers has been meeting since May 2004. The group recommends that the system be comprised of three levels of assessment;

- Level I: Clinical Eligibility
  Individual meets current diagnostic definitions.
- Level II: Functional Assessment
  Determines the intensity of service needs for those needing more intense services than outpatient counseling.
- Level III: Individual Service Plan
  Specifies services based on person-centered plan with direct consumer input that the team develops.

After reviewing over 50 tools, the team concluded that there was no one tool that satisfied the needs of all diagnostic groups. Therefore, the team chose different tools for each group with testing and implementation being at different phases for each tool.

- Mental Illness/Chronic Mental Illness Tool: LOCUS (Level of Care Utilization System for Psychiatric & Addition Services)
  After initial pilot projects, web-based software was purchased in Fall 2005 with demonstration projects in 6 counties. LOCUS will be offered to counties on a voluntary basis by January 2007.
- Mental Retardation/Developmental Disability Tool: ICAP (Inventory for Client and Agency Planning)
  Web-based software being purchased for demonstration projects in four counties by January 2007.
- Brain Injury Tool: There is no known existing tool that measures level of functioning. The team is working with the Brain Injury Council and others to develop a long-term clinically sound answer to this problem.

This effort received an appropriation of $260,000 in HF2780. This has been critical for movement forward. There are several points that are relevant:

- As more services are provided with Medicaid as the funding stream, it is critical that staff from Iowa Medicaid Enterprise be part of developing a system of which the use of functional assessment tools is a foundation. At a time when resources (fiscal and staff) are low, to be duplicating efforts or standards which increase the overall cost of service delivery.

- There is not a direct correlation between level of care and the cost of service delivery. Functional assessment is only one factor in determining cost, but does address many clinical issues that providers struggle with in determining appropriate services. Work continues by a Case Rate Team to determine the factors that would be involved in establishing a rate where the money would follow the consumer.
- As pointed out in the initial redesign document, Iowa needs to discontinue the use of "chronic mental illness" as defined in Iowa Administrative Code 441-90 as a disability category and begin to use "serious mental illness" as defined in Section 1912© of the Public Health Services Act as the disability category. This will have financial implications for counties, as some persons will qualify for services based upon functional assessment but not under the CMI definition.

D. RESIDENCY

The Commission recommends:

1. *Establishing a definition of residency. A proposed definition is listed in the definitions in appendix A. Some individuals who are present in Iowa and otherwise eligible for MHDDBI funding may not be a resident of any management entity pursuant to this definition. Funding for those individuals will be available through the state entity. See definition of "eligible non-resident".*
2. *Establishing a statewide standard for "proof of residency" that presumes an individual lives where they say they live, with minimal documentation required. We suggest the following could be used to document residency: driver's license, motor vehicle registration, mailing address, telephone bill, rent receipt, lease agreement, property tax bill, utility bill, wage stub, tax return, employment or wage records or receipts, bank account statements, or documents from the person or shelter with whom the homeless individual is staying. Residency could be also be determined by consulting a telephone or city directory, interviewing the applicant at home, or interviewing a knowledgeable third party.*
    2. *Establishing a statewide data system that identifies the residency of each individual eligible for MHDDBI funds.*
    3. *Establishing a mechanism for individuals to contest a residency determination. It is important for the mechanism to use a disinterested decision maker and allow quick resolution of most disputes.*

EXCEPTIONS TO FUNDING FOR RESIDENTS

Residency is important in the redesigned system because MHDDBI funds will be distributed to management entities based on the number of residents that are eligible for MHDDBI funds. However, not all individuals who are residents of a management entity will be eligible to receive MHDDBI funds through that management entity.

Individuals placed in or committed to a state mental health institution, state resource center, or a licensed residential facility; or receiving residential supports through a home and community based services (HCBS) waiver; or persons in the custody of the department of corrections, will not be considered residents of the management entity where they are receiving the services. Under the definition of residency found in appendix A, they will be considered absent from their home management entity during their stay in an institution or facility or receiving HCBS waiver residential services, and they will continue to receive funding through their home management entity. However, if the person meets all criteria for receiving MHDDBI funds and is placed in or committed to the institution, but is not a resident of any management entity, the state entity will provide the funding for this "eligible non-resident".

Committee Findings and Recommendations:

A definition of residency has been developed and partially implemented 10/1/06 when counties assumed the administrative responsibility for State Payment Program (SPP) individuals. During the SPP conversion process, the state established a statewide data system to track individuals. As this process is in its infancy stages, there are assorted problems to work out. The next step toward moving toward Residency and away from Legal Settlement was established in HF2780, which requires the County of Legal Settlement to fund MH/DD Services according to the County of Residence Management Plan beginning 7-1-07.

E. ***CORE SERVICES***

The Commission has identified a need for a minimum set of core services that are available to all eligible individuals no matter where they live. While this does not assure that each core service will be available in every locality, it does assure that the core services will be publicly funded by the MHDDBI funds managed by each management entity.

The Commission recommends:

1. *Maintaining the current level of services as the system moves toward requiring that core services be funded statewide. Individuals already receiving services will continue to receive services, regardless of disability. The Commission recognizes that during this transition period, management entities must be allowed to make management decisions that allow them to stay within available funds.*
2. *Requiring, by the end of the phase-in period, the following minimum services that should be publicly funded for eligible individuals:*
   a. *Coordination and monitoring services*
   b. *Community Services and Supports:*
      - *Outpatient mental health treatment services*
      - *Outpatient mental health crisis planning and intervention services*
      - *Rehabilitative services*
      - *Habilitative services*
      - *Support services, i.e. supported community living services, community support services, peer support services*
      - *Respite services*
      - *Vocational services*
      - *Educational services*
      - *Personal growth services*
      - *Recovery-oriented services*
   c. *Inpatient Services*
      - *Inpatient mental health treatment services*
      - *Sub-acute services*
   d. *Residential Services*
      - *Intermediate care facility services for individuals with mental retardation (ICF/MR)*
      - *Intermediate care facility services for individuals with mental illnesses (ICF/PMI)*
      - *Residential care facility services*
   e. *Other cost effective services, treatments and supports most likely to help an individual achieve their outcomes as identified by the individual's plan and authorized by the management entity.*

Committee Findings and Recommendations:

There has been discussion about how the concept of core services fits in with services provided based on level of functioning and need. The underlying value of core services was to establish basic services in all 99 counties. Rural counties cannot support specialty

services, but basic services could be established. Club and peer support are examples of valuable services that are typically not viable in a rural area. Of more concern is the deterioration of basic services due to lack of county financial resources. Because services to individuals with mental illness and developmental disabilities are not mandated, some counties have had to cut services to those individuals to balance the budget.

F. INDIVIDUALS SERVED BY THE SYSTEM

The Commission recommends that individuals who access the system and its services should, to the degree possible:

1. *Participate in developing, implementing and monitoring their individual service plan.*
2. *Participate or lead in defining their own needs, service responses and outcomes.*
3. *Choose and implement methods to achieve their desired outcomes.*
4. *Accept personal responsibility to achieve the goals they have established within their service plan.*
5. *Lead or participate in selecting their service coordination team.*
6. *Advocate for oneself.*

Participate in the funding of their services.

Committee Findings and Recommendations:

The committee feels this section is current with the following change:

6. Advocate for oneself. The following phrase should be added "including not participating in services."

G. SERVICE COORDINATION

The Commission recommends the following service coordination roles and responsibilities:

1. *Establish a person's eligibility for publicly funded services.*
2. *Work with the individual to develop and implement a plan for services and supports that meets the individual's needs based on person-centered planning principles.*
3. *Work with the individual to advocate for services, funds, and supports that meet their needs.*
4. *Encourage the individual in the development of skills in self-direction and planning.*
5. *Compile data that indicates whether outcomes are met, and confer with the individual to adjust the plan if desired outcomes are not met.*
6. *Facilitate service coordination team meetings, if needed.*
7. *Coordinate, broker, manage and monitor services and supports established in the service coordination plan in a seamless, integrated system of care.*
8. *Educate the individual served and others as appropriate about the disability system.*

The Commission recommends service coordination with the following characteristics:

1. *Service coordination allows access to services without a case manager if it is appropriate to do so.*
2. *Service coordination is available to any individual who might benefit, regardless of funding source.*
3. *Service coordination is flexible enough to be provided intermittently based on the individual's need.*
4. *The need for service coordination is based on functional assessment, not the number of services provided or Medicaid eligibility.*
5. *Service coordination may be provided by a natural support or by the individual with a disability.*
6. *Service coordination may include functions such as mentoring to assist a person with self-directed care, fiscal intermediaries, or benefit planners.*
7. *Service coordination is a function, not a service. It may be provided as a stand-alone resource or integrated into a support team.*

Committee Findings and Recommendations:
Service Coordination is a function that occurs at many levels but is not recognized or valued as a service by financial reimbursement. In order for this service to be a reality, the dollars will need to be allocated to making this happen.

H. ***MANAGEMENT ENTITIES***

The Commission recommends that the physical boundaries of management entities shall be a single county or a consortium of counties organized by mutual agreement as allowed by the Code of Iowa Chapter 28E.

Committee Findings and Recommendations:
At present, there are counties sharing staff but no counties have joined to become a larger management entity. This is not likely to happen given the multiple changes occurring within the whole system.

I. STATE ENTITY

The MHDD Commission recommends the following role clarifications within the state entity:

1. *The MHDD Commission should be renamed the MHDDBI Commission, to better reflect its responsibilities in serving individuals with mental health needs, developmental disabilities, and brain injuries.*
2. *The MHDD Commission should be the primary policy-making authority for the MHDDBI system.*
3. *A division or divisions should be established within the Department of Human Services that comprise the state's mental health authority, developmental disability authority, and the brain injury authority.*

Committee Findings and Recommendations:
A new "Division of Mental Health & Disability Services" has been established with a staff being hired. The MHDD Commission has been renamed the MHMRDDBI Commission. While the Commission overseas policy that affects county-funded services, there is little input in Medicaid and institutional policy. This Committee feels strongly that there needs to be good communication between the new MH/DS Division and Medicaid!
With the addition of a data specialist, a database of FY05 data from 60 counties has been created. It is projected that there will be data available from all 99 Counties, Medicaid, State Payment, and Institutions available for analysis in 2007. This is a significant accomplishment but will take more staff and resources.

J. STATE RESOURCE CENTERS AND MENTAL HEALTH INSTITUTIONS

No area has experienced more change in recent years than the area of institutional services for people with disabilities. We have learned that some people, regardless of disability, do best when they live in non-institutional, community settings. It is incumbent upon our system to direct vision, effort, and money toward developing community capacity so that those who can "live, learn, work, recreate and otherwise contribute in their chosen communities" are supported in doing so.

Our system must also continue to provide some types of care and treatment in an institutional setting. The state of Iowa does not have the community capacity to meet the needs of all eligible individuals. Our institutional settings will continue to provide service options for individuals with high medical or

behavioral needs. In addition they will continue to provide safety for both individuals being served and others living in the community.
In this section, the Commission recommends that the system develop and implement a strategy that clarifies how the system will use state-operated mental health institutions and state resource centers, how to help build community capacity to provide non-institutional places to live, and how to align institutional funding strategy with the system funding strategy.

The Commission recommends that the system develop and implement a strategy for use of state-operated mental health institutions (MHI) and state resource centers (RC), including the following:

1. *Require the state entity and its stakeholders to develop an implementation strategy that implements Olmstead and provides a seamless transition to operation of the state MHIs and RCs as specialized "niche" providers of services subject to consumer choice and emerging residential best practice trends.*
2. *Recommend a definition of the mission of the MHIs that reduces residential treatment and focuses on acute treatment.*
3. *Recommends a definition of the mission of the RCs to ensure that they are focused on serving persons who cannot be served in the community.*
4. *Monitor MHI and RC lengths of stay, budgets, staffing, bed capacity, costs per admission, and geographic areas served and require corrective action to better use resources.*
5. *Provide onsite short-term stays for evaluations or acute care stabilization.*
6. *Provide long-term care if the system fails to develop community capacity to provide such care.*
7. *Work with Department of Public Health substance abuse division to integrate access, treatments, programs, and funding for individuals with dual diagnoses.*
8. *Develop specialized forensic capacity to address the potential for violent situations that includes expertise, consistent protocols, and housing arrangements as appropriate.*
9. *Convert campus buildings for use of alternate programs operated by government and non-government providers.*

STRATEGY FOR BUILDING COMMUNITY CAPACITY

The Commission recommends that the system develop and implement a strategy for building community capacity to provide housing, treatment, and supports outside the state institutions as follows:

10. *Work with management entities to develop community capacity to serve individuals consistent with the Olmstead Supreme Court Decision.*
11. *Build community capacity by providing training and technical assistance in 'Best Practices' to providers, family members and other members of a person's support team.*
12. *Build community capacity by providing case consultation; 24-hour emergency assistance and referral; on-site evaluations (within the person's home environment if the individual is willing); off-site evaluations (within a more controlled environment); teaching centers for professionals and para-professionals; training consumers to build capacity for independent living.*

STRATEGY FOR ALIGNING INSTITUTIONAL FUNDING

The Commission recommends the following:

13. *Work towards being more entrepreneurial and competitive through such mechanisms as partnering with the private sector for collaborative programs; eliminating the Medicaid IMD (Institution for Mental Disease) exclusion (applies only to MHIs); using net budgeting; or using other mechanisms to generate additional operating revenues.*
14. *Abide by the same licensure requirements and per diem calculations and limitations as community providers.*
15. *Isolate institutional net salary appropriations and make them part of state institutions allowed costs so that a true per diem cost can be calculated.*
16. *Eliminate the county per diem calculation, and instead use only the Medicaid allowed cost calculation (currently allowed costs for Medicaid per diem calculation are different than the allowed costs for county per diem calculation).*

17. Remove the percentage caps on the per diems counties currently pay (counties currently pay only a percentage of the total amount it costs to provide services to a county funded individual). This should be done only if all the money is added to the state and federal MHDDBI fund, and only if the state institutions are subject to the same standards as other providers.

18. Assure that some expenses of the institutions are not included as allowable costs in calculating the per diem (such as special highway construction cost or capital outlay) and should not be made available to the MIDDBI fund.

19. Clarify the projected number of people at the state institutions that are "eligible non-residents" so that funding for those people can be retained by the state entity to fund their services.

20. Clarify that management entities will have full responsibility for funding the stays of all their residents at MHIs and RCs, with the following exceptions:

- *Persons who have third party coverage*
- *Persons who do not meet the eligibility guidelines of the management unit, including clinical necessity guidelines*
- *Individuals at the MHIs under Iowa Code Chapter 812 "Confinement of Dangerous Persons and Persons with Mental Incompetence*
- *Children*
- *People committed to the institution pursuant to Iowa Coder 229A*

Committee Findings and Recommendations:

Many of the items listed in this section have not been addressed, and no reports on progress have been presented to the Commission. The continuity of services from specialized institutions and programs to community-based services needs to be available in Iowa for its citizens. It is hoped that with the development of the new Division of Mental Health & Disability Service Division, there will be a stronger link between Community Services and Institutions in order to enhance communication and share similar philosophies with community services.

K. DISABILITY SERVICES FUNDING

The current methods of funding the county- managed portion of the disability system are unfair and inequitable. State dollars are not distributed based on need. Each citizen of Iowa is not contributing an equal nor proportional share. The dollar amount raised is capped so as local valuations change the contribution per person changes inversely to their ability to pay (counties with lower valuations pay more per thousand while counties with higher valuations pay less). In fiscal year 2004, the amount of tax ranges from a low of 35 cents per thousand to a high of $3.13 per thousand.

The Commission proposes to establish a levy range with a minimum and maximum rate to address the inequalities in the property taxes. The minimum of the range will assure that each dollar of taxable valuation will generate an equal levy amount to support the newly designed system, including all the core services with standard eligibility guidelines. Having a maximum eligibility rate allows those counties that want to provide more than core services to raise the money to do this.

The Commission is also proposing a case rate allocation methodology that allocates non-property tax money to each management entity based on the cost associated with that cluster of clients and the management entity's financial responsibility for those clients, less what the entity is able to raise through the minimum levy.

ASSUMPTIONS

The Commission makes these assumptions about system funding:

1. *The state, the federal government through the Medicaid program, and the management entities should each bear financial risk for this funding system.*
2. *Local property tax is a stable source of revenue when compared to state income or sales tax.*
3. *Individuals are best served when funding comes from a balanced use of federal, state, and county dollars.*
4. *Counties where the tax base is increasing need to be able to capture and use that growth for the benefit of the MHDDBI populations they serve.*
5. *It is prudent to leverage more federal dollars through increased Medicaid eligibility strategies and program coverage, while maintaining a balance of funding from federal, state and county sources.*
6. *Other support systems already in place that serve the MIDDBI populations will continue to be funded and utilized as part of a complete set of services and supports.*
7. *Data collected and analyzed by the system over the next two years will reveal how much additional revenue the MHDDBI system will need to serve additional populations and provide core services statewide.*
8. *Additional revenue to serve additional populations and provide core services statewide will come from lifting county property tax caps, additional state appropriations, increased Medicaid eligibility strategies, and other sources.*

RECOMMENDATIONS

1. *The Commission recommends the creation of an MHDDBI fund. The purpose of the fund is to provide public funding for services and supports for eligible adults. There will be two funding components. The statewide component incorporates state and federal funds and is maintained by the Department of Human Services. It includes:*
   a. *A single legislative annual appropriation (the MHDDBI appropriation) in lieu of three existing appropriations (MHDD Community Services, Property Tax Relief, and Allowed Growth)*
   b. *State appropriations for Mental Health Institutions and Resource Centers would flow into the statewide MIDDBI fund in lieu of being appropriated to the individual facilities*
   c. *State appropriations for state cases*
   d. *State appropriations for Medicaid match for adult MHDDBI services (this state appropriation is all or part of the non-federal share, depending on the service)*
   e. *Federal Mental Health Block Grant (MHBG) Dollars*
   f. *Social Services Block Grant (SSBG) Dollars*
   g. *Federal Financial Participation (FFP) portion of Medicaid dollars that fund adult disability services*

2. *The MHDD Commission recommends establishing a county property tax levy range with a minimum and maximum rate to address the current inequalities in the property tax levies among counties. This second component of the MHDDBI fund should be maintained by each management entity. The new taxation methodology would allow a property tax levy rate range that each county could levy for the MHDDBI fund. Each county would be required to impose a standard minimum levy rate. Counties could levy above the required minimum up to the maximum allowed rate.*

3. *The Commission recommends distribution of state and federal MHDDBI funds to management entities using the following methodology:*
   a. *Determine a case rate. A case rate is an actuarially determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functionality.*
   b. *Calculate the total funding each management entity will need by multiplying the number of people it serves at each case rate times the case rate.*
   c. *Distribute to the management entity from the statewide MHDDBI fund the total minus the amount of money generated by the required minimum levy rate.*
   d. *Allocations to each local management unit will change as the number of individuals receiving services changes. Allocations should be recalculated quarterly.*

Committee Findings and Recommendations:
The Department of Human Services entered into a contract with a company called Pareto Solutions. The final outcome of that contract was the development of a 'prospective' (as opposed to actuarial) model approach to case rates, based on cases actually served, aggregate cost and cost per case broken down by specific rate cells. The Model has the ability to generate cost and utilization information based under three different scenarios: A) Best Practice Approach; B) Current Reality; and C) Benefit Plan-Controlled.
This Model was designed to analyze SPP cases only as a starting point in our effort to develop a funding system that will allow the funding to follow the consumer as a basic allocation method. The department is preparing a report to go to the legislators in 2007.

Phase-In Strategy

Committee Findings and Recommendations:
We are at least one to two years behind the recommended phase-in strategy originally recommended by the Commission.