

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION  
July 21, 2011, 9:30 am to 3:00 pm  
Iowa Lutheran Hospital, Conference Rooms A & B, Dining Level B  
700 East University Avenue, Des Moines, Iowa  
MEETING MINUTES

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MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick	Gary Lippe
Lynn Crannell	Zvia McCormick
Lynn Grobe	Susan Koch-Seehase
Jan Heikes	Gano Whetstone
Richard Heitmann (by phone)	Jack Willey
David Hudson	Craig Wood

MHDS COMMISSION MEMBERS ABSENT:

Senator Merlin Bartz	Chris Hoffman
Richard Crouch	Cindy Kaestner
Senator Jack Hatch	Linda Langston
Representative Dave Heaton	Laurel Phipps
Representative Lisa Heddens	Dale Todd

OTHER ATTENDEES:

Pam Alger	DHS, Targeted Case Management
Marilyn Althoff	Hills and Dales
Tammie Amsbaugh	U of Iowa, CDD and Iowa MHDS, IME
Bob Bacon	U of Iowa, Center for Disabilities & Development
Ronda Bennett (phone)	Iowa Department of Inspections and Appeals
Teresa Bomhoff	Iowa Mental Health Planning Council; NAMI
Diane Diamond	DHS, Targeted Case Management
Connie Fanselow	DHS, MHDS, Community Services & Planning
Becky Flores	DHS, MHDS, Community Services & Planning
Jennifer Harbison	DHS Legislative Liaison
Karen Hyatt	DHS, MHDS, Community Services & Planning
Julie Jetter	DHS, MHDS, Community Services & Planning
Gretchen Kraemer	Iowa Attorney General's Office
Karalyn Kuhns	MHDS Interim Division Administrator
Todd Lange (phone)	Office of Consumer Affairs
Bob Lincoln	Director, County Social Services (CSS) Region
Jerry Mayes	Olmstead Consumer Task Force
Liz O'Hara	U of Iowa, Center for Disabilities & Development
Kelley Pennington	Magellan Health Services
Mary Peterson	DHS, Mental Health and Disability Services

OTHER ATTENDEES (continued):

John Pollak	Legislative Services Agency
Eric Preuss	Iowa Department of Public Health
Ann Riley	U of Iowa, Center for Disabilities & Development
Rik Shannon	Iowa Developmental Disabilities Council
Heidi Smith	Brain Injury Association of Iowa
Casey Westhoff	The Arc of Iowa
Robyn Wilson	DHS, MHDS, Community Services & Planning

WELCOME AND CALL TO ORDER

Chair Jack Willey called the meeting to order at 9:45 am. Jack welcomed Commission members and guests and led introductions. No conflict of interest issues were identified for this meeting. Business items were tabled pending the establishment of quorum.

DHS-MHDS UPDATE

Karalyn Kuhns presented the DHS update.

DHS Appropriations - Karalyn handed out a summary of DHS appropriations shared with Council on Human Services by Jean Slaybaugh, the administrator of the Fiscal Management Division. The summary (Attachment 1) shows a comparison of Fiscal Years 2011 and 2012 with variances. Karalyn noted that the appropriations bill has not yet been signed, but the summary reflects the figures contained in the bill if there are no item vetoes. The numbers are a combination of general funds and other appropriated funds. The State Fiscal Year (SFY) 2011 figures are after the \$83.7 million de-appropriation. For SFY 2012 there are some requests for restoration of funds.

Karalyn said it is clear that service delivery will be tight and it will be important that carry-forward funds be received. The General Administration numbers include some carry-forward money that is critical to replacing some positions that have been lost. There was a reduction in force (RIF) of 14 probationary people in field operations on July 1 because the budget was still uncertain. Supplemental funding through the end of June allowed maintenance of the level of beds that existed on January 1. Going forward, six children's beds are expected to be added back at Cherokee. Eldora was at 167 beds last fall; they are now at 130 beds and that is where they are expected to be maintained in 2012. The two Resource Centers will continue the planned reduction of 12 more beds.

The MH/DD Growth Factor will have a \$16 million increase. The MH/DD Community Services Fund is shown at \$19.1 million on this summary. That figure includes \$4.9 million in federal TANF (Temporary Assistance for Needy Families) dollars, so the number would adjust to \$14.2 million, which will be reflected in the information that Robyn and Julie will share later.

Mental Health & Disability Services Redesign – A \$250,000 appropriation to DHS is called for to implement and assist in the workgroup process. Karalyn said she believes that funding will remain in the bill to support staffing and facilitation of the workgroups. The budget is a 2-year plan as requested by the Governor. Most of the SFY 2013 amounts are set out at 50 to 100 percent of the SFY 2012 level and the Department of Management (DOM) will be giving more instruction on preparing for the 2013 budgets.

Teresa Bomhoff commented that the Mental Health Planning Council had received information indicating that the January 1 bed levels which are being maintained were artificially low because of year end holiday discharges. She asked if there was any chance of those levels being increased. Karalyn responded that the Independence MHI will continue to operate one combined unit for children and adolescents and the Mount Pleasant MHI will lower the number of acute psychiatric beds and increase dual diagnosis beds. She said the budget at Clarinda is very tight and the goal is to decrease the geropsychiatric unit and as that happens, increase the number of acute care beds.

Craig Wood commented that the MH/DD Growth Factor is less than half of what ISAC (Iowa State Association of Counties) said was necessary to replace the ARRA (American Recovery and Reinvestment Act) dollars. He noted that changes in the FMAP (Federal Medical Assistance Percentage) and the loss of ARRA program funds will have a \$40 million impact on counties, which will be a problem in SFY 2012.

Jan Heikes asked who works on the Uniform Cost Report. Jennifer Harbison responded that DHS and ISAC are involved, and she has asked for some clarification from Senator Hatch, which she hopes to have soon.

NASMHPD Conference – Karalyn noted that she just returned from the meeting of the National Association of State Mental Health Program Directors (NASMHPD) in Washington, where she heard some sobering information about the budget deficit from the Congressional Budget Office, but also noted that it is clear that people realize that Medicaid costs and behavioral health care are valuable, and especially in hard economic times those programs need to be able to serve more people.

Karalyn noted that Kathryn Power, Director of the Center for Mental Health Services at SAMHSA (Substance Abuse and Mental Health Services Administration), spoke and shared SAMHSA's strategic initiatives. She said the overall themes are innovation and change and that behavioral health is being imbedded in discussions across all types of services – housing, employment, health, and health care reform – and integrating behavioral health care needs across all fronts. Recognizing that when resources are scarce, it is more important than ever to work together and braid funding sources. There is also recognition of co-occurring conditions and the importance of keeping the consumer at the center of integration efforts and that behavior health is essential to overall health.

Half of all lifetime mental health and substance abuse disorders start by age 14; three-quarters of them by age 24. Twenty-three percent of our population is affected by a mental health or substance abuse disorder. About half the people with a lifetime history of a mental health disorder also have a lifetime history of at least one addictive disorder. By 2020, mental health and substance abuse conditions will surpass physical diseases as a major cause of disability. Untreated physical health conditions (heart disease, diabetes, etc.) in people with serious mental health conditions result in a 25-year average reduction in life expectancy. Early identification and treatment is critical to improved health and SAMHSA is moving to more of a focus on prevention and early intervention, especially in children.

SAMSHA's Eight Strategic Initiatives are:

1. Prevention of Substance Abuse and Mental Illness
2. Trauma and Justice
3. Military Families
4. Recovery and Support
5. Health Reform
6. Health Information Technology
7. Data, Outcomes, and Quality
8. Public Awareness and Support

The complete document is available at: [www.samhsa.gov](http://www.samhsa.gov).

## MENTAL HEALTH AND DISABILITY SERVICES REDESIGN

Karalyn Kuhns and Jennifer Harbison presented an update on the mental health and disability services redesign legislation. They shared a summary handout of the Senate File 525 workgroups. (The summary document is available on the DHS website at: <http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>).

Senate File 525 defines disability services as “services and other supports available to a person with mental illness or an intellectual disability or other developmental disability.”

Intent: The stated legislative intent is to redesign the system for adult disability services:

- Shifting the funding responsibility for the nonfederal share of adult Medicaid disability services from the counties to the state
- Reorganizing adult non-Medicaid disability services into a regionally administered system with multiple local points of access to both Medicaid and non-Medicaid services
- Replacing legal settlement with residency as the basis for determining financial responsibility for publicly funded disability services
- Meeting the needs of consumers for disability services in a responsive and cost-effective manner

Interim Committee: There will be an Interim Committee of legislators only with equal representation from both chambers and both political parties to work on Iowa Code changes based on recommendations from workgroup proposals. The Committee will be meeting during the same period of time that the workgroups are meeting. They will be looking at:

- Making recommendations based on proposals made by the workgroups
- Addressing property tax issues
- Ensuring that the state maintains funding commitments to the redesigned system
- Making revisions to Iowa Code Chapter 229 (involuntary civil commitments)
- Making revisions to Iowa Code Chapter 230A (community mental health centers) to conform with the redesigned system
- Amending existing code references from “mental retardation” to “intellectual disability”
- Considering the July 1, 2013 repeal of county disability services funding and all funding sources to replace the county levy for adult disability services

Timeframes:

- Interim Committee members will be involved in the workgroup process and begin formal discussions of the workgroup proposals starting in October
- Detailed and final proposals from the workgroups are due to the Interim Committee by December 9
- The Interim Committee is to make their recommendations during the 2012 legislative session
- The target date for full implementation is July 1, 2013

DHS Responsibilities are to design and facilitate the following workgroups and process:

- Adult mental health system redesign
- Adult intellectual and other developmental disability system redesign
- Children’s disability services
- Regional administration of non-Medicaid adult disability services
- Involuntary Committal (Court MH) Workgroup: Joint DHS and Judicial Branch
- MHDS Service System Data and Statistical Information Integration
- Best practices and programs in services for persons with brain injury

Karalyn noted that the redesign has been discussed for many months and there was hope the process could start as early as May, but with the extended legislative session and no language in the bill to allow the money to start being used upon enactment, the process cannot start until the bill was signed by the Governor, which is expected to happen next week. The result is that there will be a great deal of work to get done in a short period of time.

The Department received over 240 requests to participate in workgroups and appreciates the many offers of assistance. It will take a lot of people, but the workgroups will really have to keep focus on their charge and moving forward; compromise will be necessary. Karalyn and other staff are working with Director Palmer

to make the final decisions about the workgroup membership. Groups will be narrowed down to about 12 to 15 members each to make them manageable.

Membership will include consumers, service providers, county representatives, advocates, balance of rural and urban interests, and representatives of the Department of Public Health (IDPH) where relevant.

Adult Mental Health and Intellectual Disability Workgroups - The proposals for the Adult Mental Health and Adult Intellectual Disability Workgroups are expected to include clear definitions and requirements for:

- Eligibility criteria for individuals
- Array of core services to be delivered
- Outcome measures that focus on consumer needs
- Quality assurance measures
- Provider accreditation, certification, or licensure requirements
- An input process to engage local consumers, providers, and counties in developing regional plans and provisions
- Provisions for DHS and regional representatives to regularly engage in discussions & service improvement

Everything the workgroups do is to be grounded in Olmstead and in keeping with the principles of the Olmstead Plan.

The MH and ID/DD workgroups are also expected to address:

- Continuing the leadership role of the Medicaid program (medical or behavioral health homes)
- Implementing mental health crisis response services statewide (with regional flexibility)
- Implementing a subacute level of care to provide short term residential mental health services
- Developing a proposal to address service provider and workforce shortage issues, including barriers to recruitment and retention, review of training, reimbursement, and professional scope of practice
- Developing a proposal to address co-occurring mental health, intellectual disability, brain injury, and substance abuse disorders
- Cost estimates for the proposals

Children's Disability Services Workgroup: The children's workgroup will have a similar membership with the additions of the Department of Education, child welfare, and juvenile court representation. Their timeframe is two years and their final proposal is due December 10, 2012.

Regional Workgroup: The membership for the Regional Workgroup also includes rural and urban supervisors, rural and urban central point of coordination (CPC) administrators, and other experts. They are required to look at:

- Regions that will consist of contiguous counties

- Evaluating the capacity of the proposed regions to provide core services and perform required functions
- Each region encompassing at least one community mental health center (CMHC) or federally qualified health center (FQHC) with qualified providers of psychiatric services
- Each region encompassing or having reasonable proximity to a local hospital with a psychiatric unit or an MHI
- Creating an administrative line of accountability with the lead agency, and shared county staff or other means to keep administrative costs at no more than 5% of expenditures

The Regional Workgroup must develop a proposal for adult non-Medicaid disability services to be administered on a regional basis with multiple local points of access. In doing so, they must consider:

- Necessary modifications to Iowa Code Chapter 28E (Intergovernmental Agreements)
- Performance based contracts with DHS
- Multiple point of access; creation of a 3-year service plan; provisions for implementing performance based contracts, uniform cost reports, and consistent non-Medicaid service payment and reimbursement methodologies
- Determination of Medicaid Targeted Case Management (TCM)
- Communication with DHS re Medicaid services
- Size of the Intellectual Disability population
- Full participation in regional entities
- Provisions for dispute resolution
- Consumer appeal process
- Financial management provisions
- Other criteria for establishing regions

They must also provide a cost estimate for the regional proposal.

Judicial Branch/DHS Workgroup: This is the continuation of the Court Mental Health group convened last year by DHS and the Judicial Branch to improve the process for involuntary commitment for mental health or substance abuse treatment. It will retain the same membership as last year, with additional stakeholders added if necessary.

Service System Data Workgroup: In addition to the redesign workgroups, SF 525 establishes a group to develop an implementation plan for an integrated data and statistical information system for mental health, disability services, and substance abuse services that meets all federal requirements. The membership will come from DHS, IDPH, and the Community Services Network of ISAC.

PMIC Workgroup: There will also be a PMIC (Psychiatric Medical Institution for Children) and Related Services Workgroup to develop a plan for transitioning the administration of PMIC services to the Iowa Plan. Since it is a Medicaid funded service,

IME (Iowa Medicaid Enterprise) will take the lead with that group. It will proceed separately from the Children's Workgroup.

There is also money appropriated to the Department of Corrections (DOC) to lead another group that will be looking at geropsychiatric care and care of all individuals under the custody of the State. DHS is a part of that and their report is due on November 15.

Brain Injury Workgroup: The description of the Brain Injury (BI) Workgroup was inadvertently omitted from the summary, so the document will be revised and reissued. The BI group has a different focus and a different timeline. They are charged with reviewing the best practices and programs utilized in other states and identifying new approaches to address the need for publicly funded services for persons with brain injury. Their proposal may be submitted after the submission date for the other workgroups.

Gano Whetstone commented that she is interested in seeing drug education programs in the schools delivered by mental health professionals rather than law enforcement officers.

David Hudson asked which group is the most controversial. Jennifer responded that it would probably be the regional group because there are many diverging opinion and challenges in different areas of the state can vary widely. All counties will need to figure out how to come together to form regions; some have already done it very successfully, while in other areas it has not really been considered. All of the workgroups have huge tasks ahead of them.

Craig Wood asked for clarification on the statement under legislative intent regarding multiple point of access to "adult disability services both paid for by the Medicaid program and not paid for by the Medicaid program." Jennifer responded that "access" should not be read to mean "authorization," because no one other than Medicaid can authorize Medicaid services.

Jennifer added that the Department also received legislative approval for a new MMIS system and as part of the federal affordable health care act there are opportunities around new eligibility processes and systems for Medicaid in conjunction with the expansion of eligible populations in 2014. In Iowa it may be anywhere between 100 and 200 thousand new eligible persons, including those who qualify for the health benefit exchange, so Medicaid application may look very different in a few years than it does now. There is still a lot of work in progress and much more to be defined, but people will need to be connected to a system that can help them move between coverage groups, depending on their eligibility.

Craig Wood asked for a clarification on whether the Adult MH and Adult ID workgroups were combined or separate. Karalyn responded that there would be a separate

workgroup for each population, but they will be looking at the same kinds of issues and reporting the same information.

Craig commented that the community mental health center language in the final version of SF 525 is somewhat different than the language the Commission originally submitted. He noted that on page 18 it says that the intent of the legislature is that state funding will be sufficient for core services. He also noted that it calls for Chapter 230A to be revised if necessary to conform to system redesign recommendations.

Jan asked if the workgroups activities were just waiting for the signing of the bill. Jennifer responded that it is a number of things, including the bill signing, finalizing the membership of the workgroups and finding facilitators. Karalyn said MHDS is hoping to use the \$250,000 funding to secure someone to do the facilitation work because the Division simply does not have sufficient manpower to staff and facilitate all the group, gather and distribute all the information, and write the necessary reports. The Department cannot contract to do that work until the bill is signed.

#### WRIGHT COUNTY TO JOIN COUNTY SOCIAL SERVICES REGION

Julie Jetter introduced Bob Lincoln, who heads the County Social Services (CSS) region. Wright County is working on joining the CSS, although they do not yet have a new management plan ready to share. Brad Leclone, the Wright County CPC, could not attend today, so Bob came to answer any questions. Julie noted that no vote from the Commission is requested today, Bob is here to share information about the proposed changes. Julie shared a handout on Brad's timeline for the change and analysis of the differences to the plan. It is expected that the changes to the plan will not be adverse to or more restrictive for consumers.

Bob explained that after discussions, it was determined that both Wright County and County Social Services could benefit from joining together. The eligibility criteria remains the same, the only differences are in process. CSS authorizes mental health centers to be access points. CSS also has a distinct program between mental health and disability services. Wright County has two people who are credentialed with the SIS (Supports Intensity Scale) tool for assessments. Wright County can also provide more administrative support and talent for CSS, which will assist them in fully implementing their systems of care approach. Wright County will be adding access to jail services, which were not available before.

Jan Heikes asked what the levy rates are for the counties in the CSS. Bob responded that they range from about 77 cents to \$1.50 and all are at full maintenance of effort. Bob added that this is good timing because Wright County will finish up their SFY 2011 as a stand-alone and join the CSS in time to provide complete data for all six counties for SFY 2012. Bob said the ISAC CSN (Community Services Network) data base has made it very easy to move the information from Wright County and put it under the CSS as county of responsibility, which makes coordination of services and accounts

seamless. Julie added that they are also working with DHS on making the necessary changes to the State Payment process and the institutional billing process.

Teresa Bomhoff asked Bob to list the counties in CSS. Bob responded they are Butler, Cerro Gordo, Mitchell, Floyd, Black Hawk, and now, Wright. The total population will be about 230,000. Bob said they have been trying to model a more effective way to deliver services, have made some mistakes, and have learned a lot. He said they are very committed to local county access and flexibility. They look at the regional administrative structure as making dollars available to all six of the counties and having standardized policies and procedures to empower local offices to be flexible and responsive to clients and consumers.

Jerry Mayes asked if Bob saw a maximum size for such an arrangement. Bob responded that from the administrative standpoint that wasn't much of an issue, but for collaboration and effective representation, as in traveling to meetings, size can become a complication. Bob said they have a CSS public Board meeting every month and people are encouraged to attend. They make an effort to locate those meetings where there is good access, rotating through the member counties. As the timeline indicates, a public hearing is scheduled for next week.

#### COUNTY FUNDING UPDATE

Risk Pool and Waiting List Funding: Julie Jetter and Robyn Wilson presented an update on Risk Pool and Waiting List funding. The legislature appropriated \$10 million for the Risk Pool to help counties with waiting lists in Senate File 209. The application date for counties was originally July 15; it has now been extended to 10 days after the bill is signed by the Governor.

The first round of this money is limited to counties that had a waiting list on April 21, 2011. There are four counties that qualify: Clinton, Jackson, Polk, and Scott. They have to do clear accounting on an individual basis of the people who are going to be removed from that waiting list and at the end of the year they have to report back to the Risk Pool Board to show they spent the money on those individuals. That type of accounting is a new requirement.

The second round of applications is due December 1 for counties that establish waiting lists after April 21, 2011. Those funds will include anything left over from the \$10 million that is not spent in the first round, \$1.3 million current carryover, and any amounts rebated to the state by the counties to keep their fund balances below 10 percent. Johnson and Osceola counties have established waiting lists as of July 1. Julie said she expects there will be additional counties eligible to apply before December.

Human Services Appropriations: Julie and Robyn handed out copies of the health and human services section of House File 649, which includes growth dollars, property tax relief dollars, and all of the dollars that will go to the counties.

The first item, Section 42, is property tax relief at \$81,199,911. This was cut from \$88.4 million a couple of years ago in the across the board reductions and has not been brought back to its previous level. That money is divided among all counties.

The next section (43) is the \$10 million in Risk Pool funding. Section 44 is the allowed growth dollars of \$54,697,893. There is also \$10 million added in from Senate File 209. Overall this equates to an increase of \$16 million to counties for SFY 2012.

The next section (45) used to be called the Leadership fund, and is now called additional growth. To qualify for the additional growth fund of \$28 million, counties have to be at 100 percent levy and at a 15 percent or less fund balance for SFY 2010. There is new language which makes Story County eligible; they are levying at 92 percent and operating with a negative fund balance.

Robyn explained the formula:

- Start with allowed growth of \$54,697,893 (page 3, Sec. 44(3))
- Subtract additional growth of \$28,000,000 (page 3, Sec. 45(4))
- The result is \$36,697,893 (page 3, Sec. 45(5))
- Add \$13,075,453 (page 5, Sec. 45(8))
- The result is \$49,773,346 (page 4, Sec. 44(6)) for growth

Every county is eligible for the MH/DD community services fund if they have turned in their data reports and have an approved management plan, so every county is eligible for part of \$14,187,556 (page 4, Sec. 44(6)). Of the \$49.7 million for growth, \$12 million comes off the top for regular growth. All the counties who have met their reporting and plan requirements are eligible for part of the \$12 million. That leaves \$37 million left to be distributed to counties that have a 100% levy for SFY 2012 and a 25% fund balance for SFY 2010.

The growth and the community services amounts are added up and this is the pre-withholding amount. Counties that have a levy of 90% for SFY 2012 and a fund balance of less than 25%, they are potentially eligible to get their money. Then there is a second calculation. Counties that have fund balances under 5 percent get 3 percent of their gross expenditures added on to their pre-withholding amount. Counties that have fund balances between 5 and 10 percent get 2 percent of their gross expenditures added. Counties that have fund balances between 10 and 15 percent are "ledge counties" – if they have a fund balance over 10 percent, they can't lose any more money than the amount they are over 10 percent. That amount is subtracted from what they are eligible to receive. Once they reach the 10 percent, however, the \$13 million that was added on to the \$36 million is taken away, so there may not be any money available for counties over 10 percent. That is the potential this year.

Counties that have over 10% a fund balance can rebate the state the amount of dollars they are over 10 percent and become eligible for growth and community services, and especially for targeted and additional growth. Robyn said they are projecting that there will not be any funds available for counties with balances over 10 percent. Julie said 16

counties have already sent in rebate checks and it is anticipated that 19 or 20 counties will participate in the rebate. The remaining counties are waiting until the Governor signs the bill before they issue the check. They have 10 days after enactment to make the rebate.

It is a complicated formula. Robyn said that without the rebates the counties with fund balances between 10 and 15 percent would get about 30 to 35 percent of the money they are eligible to receive. With the rebates received, counties with balances under 10 percent get about 99% of the money they are eligible to receive. With the projected rebates, the counties under 10% would get 100% of their pre-withholding amount but the 5 to 10% counties would not get the additional 2% and the counties under 5 percent would get about 2.6% of the additional.

Neil Broderick asked about how much money is actually rebated back to the state. Julie responded that this year it is expected to be about \$4 million. Robyn said there is conflicting language about where the rebated dollars will go. First there was language that it was to go into the Allowed Growth Fund. The newest language says it will go into the waiting list fund. That will have to be resolved.

Julie said the counties that are suffering the most are the counties that already had a negative fund balance because they are losing dollars as more counties become eligible to share in the fund. Robyn noted that when the county fund balances for SYF 2010 are calculated, the ARRA savings are subtracted so a county may not have realized that for this calculation they were going to have a negative fund balance.

Craig Wood commented that counties are supposed to submit a property tax levy to the Department of Management (DOM) and DOM is supposed to return to the county auditor what their levy amount will be based on property tax relief. If you reduce the amount of property tax relief by \$6 million, as was done, then automatically the levy should stay up, but DOM applies the \$88 million, not the \$81.2 million, which he said does not seem to align with the Iowa Code requirements.

## LEGISLATIVE SESSION WRAP-UP REPORT

Jennifer Harbison presented an update on the 2011 legislative session. Jen said it was her first session with the Department and there was a lot of activity. She gave an overview of the bills impacting mental health, developmental disabilities, intellectual disabilities, and brain injury.

SF 209 - One of the early bills, House File 48, later became Senate File 209, which was signed by the Governor in April. It contained the \$20 million dollar appropriation as well as the repeal of the current county levy system effective July 1, 2013. The direction for the spending of the \$20 million appropriation contained in House File 649, as Robyn and Julie discussed earlier.

SF 525 - Karalyn Kuhns talked about Senate File 525, which calls for the redesign workgroups and appropriates \$250,000 for the Department to use in the redesign activities. The Governor has not yet signed SF 525. There has been some information that a bill signing may be scheduled next week. The Department will share that information when it is confirmed. There were many drafts and changes to SF 525 and it was one of the bills that made it into the last week of June and one of the first to get agreed to in conference committee. There is still some language that needs to be cleaned up by line item veto so that money is not directed to be spent in two different ways.

HF 649 - House File 649 is the Health and Human Services appropriations legislation, which was another fascinating bill to watch. It started in the House, was amended by the Senate, and the incorporated by the House into the Omnibus Budget Bill, and went back to the Senate. It was the last bill to get agreement and was finally approved on June 30. It additionally appropriated \$5 million to three HCBS (Home and Community Based Services) Waivers – Children’s Mental Health, Intellectual Disability, and Brain Injury – to address the waiting lists. The goal was to eliminate the waiting lists for those waivers.

Medicaid Cost Containment – The Legislature approved the Governor’s cost containment efforts around Medicaid. One of those items was to reduce respite hours to 48 hours per month. When Governor Branstad came into office, one of the things he said he wanted to do was to fund Medicaid exclusively with general fund dollars, not one-time dollars. Previously, one-time funds, including ARRA dollars had been used for Medicaid funding. With those dollars going away this year, the State was going to have to come up with an additional \$5 million just to maintain the status quo in the Medicaid program. Even before taking office the Governor said we wanted to look at cost containment measures. Every area of the Medicaid budget was reviewed for potential cost containment opportunities and the Governor received a list of possible items totaling \$42 million.

The Department as a whole actually got an increase of 27% this year because the \$5 million shortfall was replaced with general fund dollars. The \$42 million list was presented to the Health and Human Services Subcommittee in February by the LSA (Legislative Services Agency) and additionally Medicaid Director Jennifer Vermeer presented the list to them. The list contained, for example, the respite cut, changing funding for nursing homes, pharmacy assessment, additional control over provider payments, and many other items. Throughout the session, the list kept changing, and by the time the legislation passed, it wasn’t easy to identify which items were on the list. The legislation included directions to the Department to implement the Governor’s cost containment measures, with one chiropractic exception, and enact emergency rules to do so by July 1.

Since session did not end until June 30, it was clear that even with emergency rule-making procedures, the measures could not be implemented on July 1, because there are still notice requirements and procedures to complete. When the respite change

was taken to the Administrative Rules Committee, they heard from a lot of families, consumers, and providers that they were very unhappy about the reduction in respite hours and recognized that perhaps the issue should be looked at more fully. The rule was reconsidered. The Department pulled the rule to look at re-crafting it. Director Palmer talked to the Governor's Office and met with legislators including Representative Heaton, Representative Heddens, Senator Hatch, and Senator Seymour. There will be continued discussions. If it does go forward in some form, there will be opportunities for additional public comment. It is not completely resolved, but people are leaning toward not implementing that rule change. Jen said that this provision was expected to save \$2.5 million, so if it is being taken off the table, there will need to be a strategy to keep the budget whole. So, while \$2.5 million sounds like a relatively small amount of money to the whole Medicaid program, it really is important.

Teresa Bomhoff commented that the proposed change could result in higher costs to the Medicaid program if families cannot get the respite hours they need and have to place children in more restrictive and higher cost out of home settings. Jen added that new and updated information also needs to be provided to case managers to make sure the services are being used in the way they are intended and that Medicaid members are using the best service to meet their needs.

HF 649 also contains a provision to carry forward \$2 million in Decat[agorization] funds to a revolving loan fund to be created in the Iowa Finance Authority (IFA) to allow individuals flexibility to borrow money to build or rehabilitate a home for people on HCBS Waivers. IFA will be promulgating the rules for that program.

In the standings bill that is still a \$100,000 for a project Hills and Dales in Dubuque is already working on, so there are some exciting things going on to help support people in living in their communities.

HCBS providers also received an increase in HF 649 to restore rate cuts of 2.5% that happened two years ago. It is not without controversy and there is a push for the Governor to possibly veto it. It is a \$1.5 million increase to restore rates to the providers with a \$3 million impact to counties.

SF 525 also contains provisions for doing a lot of work around PMICs. Remedial services were transitioned to Magellan effective July 1 and are now called Behavioral Health Intervention Services (BHIS). A similar transition is planned for PMIC services.

At the end of session there was some news about negative things happening at Residential Care Facilities (RCFs). SF 659 gave some direction for the Court Mental Health group to look at that issue, so some new members, including the Department of Public Health and the Department of Inspections and Appeals will be added to that group. All the interim committees have to be approved by the Legislative Council, which meets on August 16. That is when the official appointment of legislators to committees is made.

A lunch break was taken at 12:00 p.m.

The meeting reconvened at 12:50 p.m.

#### APPROVAL OF JUNE MEETING MINUTES

Richard Heitmann joined the meeting by telephone, establishing quorum. Neil Broderick made a motion to approve the June 16 minutes as presented. Lynn Crannell seconded the motion. The motion passed unanimously, with Richard Heitmann voting by phone.

#### DISASTER MENTAL HEALTH SERVICES UPDATE

Karen Hyatt reported on the Disaster Behavioral Health Response Team (DBHRT) and disaster mental health efforts. DBHRT members have been deployed and active along the Missouri River since the first week in June. Karen said the ability of the team to respond has surpassed the original expectations. They have had the capacity to do work such as safety education and pre-evacuation education, which they had not expected to do. That capability freed up National Guard personnel for other tasks. Team members paired up with AmeriCorps volunteers and went door-to-door in a Pottawattamie County area of about 6000 homes that were at high risk of evacuation. Over the course of two weeks, they visited over 5300 homes. They talked with people about how to plan, how to be safe, conducted special population registration, and met with families to make sure they understood their responsibilities. After assembling a special population registration list of about 575 people, they went back out and met with those families to make sure they knew that they were still responsible for their own safety. In Blencoe they went to all 64 houses in town and gathered needs information so that a town evacuation plan could be made.

Karen noted that unfortunately people have come into the State selling sub-standard trailers to vulnerable people who have been displaced. Living in poor conditions in campgrounds has enhanced stress and feeling of isolation for people who are already out of their own homes. Adolescents are experiencing a lot of stress about the start of the school year. They are uncertain about where they will be attending school and may be separated from friends and teachers they know.

There are 458 members on the DBHRT team. There have been as many as 74 working on the same day and volunteers have driven as far as 3 to 4 hours one way at their own expense to work. Team members from the local area may not be able to volunteer because they are affected by the flooding as well.

There are still efforts ongoing in Benton, Tama, and the Project Recovery counties, which will still be active through the end of September. Karen said that people who don't live in the area don't really comprehend the extent of the impact. People have lost jobs because of business closures. Those who still have jobs may now have to drive

two to three hours to get to work because of where they had to relocate and multiple road closures.

DHS has extended eligibility for food assistance and child support so that people who have relocated in Nebraska can continue to get access for at least six months after leaving the State. Karen said she doesn't expect that Iowa will get federal individual assistance for the western side of the State because the actual homes that are completely destroyed due to flooding are not high in numbers and much of the impact is in things that aren't counted for federal declarations, such as lost employment and people who have had to move out of their homes and close their businesses.

Behavioral health now has an ongoing seat at the State Emergency Operations Center, which it didn't have before. Karen said she goes three times a week and that provides first hand access to information that helps the teams do better work. Karen shared some examples of the situations people are facing. She said there is a whole neighborhood in Council Bluffs that is getting sand in their basements that has to come from the levee. They are not allowed to pump out their basements because that could have a negative impact on the levee, and they can't live in their homes, but there is no assistance them under that circumstance.

Karen also told the story of couple who had been displaced from their home. They had been in fire within the last year and are still recovering from burns. Their dog saved them from the fire, so they were unwilling to put the dog in a shelter. The woman works in Nebraska and her employer has allowed her to stay at her place of employment; the man is living with the dog in a county run campground in a sub-standard camper without running water and air conditioning. They have a daughter who wants to go to her regular school and is probably going to school in Nebraska. It is difficult and time consuming to travel between to two locations because so many roads are closed. The man says he fantasizes about going to prison, because it would be better than his current living arrangement.

Lynn Grobe said that when the DBHRT team went door-to-door in the Council Bluffs area they educated a lot of people who really needed information about what was going on. Karen said that of the sample of 5300 homes they visited, 35% said they don't watch the television news, 42% said they don't get the newspaper, and 38% did not have Internet access. She said they learned that sometimes at the program and planning level we make false assumptions that people are better connected than they really are, and there were many who didn't have any real way to know what was going on even in their area. Karen said families have relocated all over Iowa in State parks and county campgrounds. State campground fees have been waived. County campgrounds have reduced fees, but cannot afford to waive them completely. DBHRT is servicing six different campgrounds right now and has been making referrals to the Iowa Disaster Human Resource Council. Churches are providing things like meals and clothing. Karen said it is important that people in the rest of the state understand that just because the water recedes, the emergency isn't over – the clean-up, recovery, rebuilding, and stress will continue for some time.

## UPDATE ON LEGAL ISSUES

Gretchen Kraemer presented an update on recent legal decisions of interest:

Mulhern v. Catholic Health Initiatives - The Iowa Supreme Court case of *Mulhern v. Catholic Health Initiatives* is an appeal filed by the family of a woman who committed suicide three weeks after being discharged from in-patient care at Mercy Franklin Center. It is a professional negligence case and one of the questions was whether or not the decedent owed a duty of self-care in a non-custodial setting. It was important to the court that she was on out-patient status at the time of her suicide. A jury found that the woman was 90% at fault for her own death and that the hospital and doctor were 10% at fault. The decision details at length the efforts of the professionals involved, which seems to be a clue to providers about what is important as they are planning services. The court discussed:

- Education about the nature of her illness and treatment options
- In-depth discussion about treatment
- Trying to dissuade her from leaving the hospital the first time she asked
- Partial hospitalization was offered
- She had been determined to have met her in-patient goals
- Instructions and emergency numbers were provided upon discharge and reviewed several times
- She had agreed that she understood and knew how to access help if her symptoms worsened and agreed to do so

The Court paid attention to the discharge plan, so the lesson for providers is to make sure that discharge plans are very clear, that patients understand what to do if they feel worse, what the steps are they need to take, and feel linked up to help.

State v. Meyers - The next case is *State v. Meyers*, a criminal case dealing with the nature of consent to sex. In this decision the Court showed leadership in determining what it means to be “against ones will.” The case involved a man who had molested his step-daughter. He moved in with the family when the little girl was six, and about a year later he went to jail for sexually molesting her. When he was released from prison five years later, he rejoined the family. There was physical and mental abuse in the household and by age sixteen he had gotten he daughter addicted to crack cocaine. The mother eventually got an Order of Protection and he was removed from the household, but the sixteen-year-old daughter went to live with him. He had been the controlling factor in her life. She was later involuntarily committed for substance abuse treatment and wrote letters detailing her sexual relationship with the step-father. He was again charged with sexual abuse of a minor. The court looked at the whole spectrum of what had happened in this girl’s life and ruled that under the circumstances she did not have the capacity to consent to a sexual relationship with him. That was critical to a finding that he had acted against the law.

The court reviewed undue influence in contracting and wills as an area of analogy. They looked at all the circumstances, including psychological factors to find that there was no need to prove mental disease or defect to find that she lack capacity to consent. They said, “the structure of the statute does not preclude psychological circumstances that could work to establish non-consent.”

Kestel v. Kurzak - The case of *Kestel v. Kurzak* is a statute of limitations decision issued by the Court of Appeals on July 13. It involves an individual who brought sexual abuse claims against the Catholic Diocese of Sioux City. Iowa has a two year statute of limitations from the time of an injury, which is tolled if you are not aware of the injury. This case was about when the person became aware that there was an injury, for this person it was at least 10 years after he had suffered psychological difficulties and the Court said that was too late.

In re R.G. – The case of *In re R.G.* is a CINA (Child in Need of Assistance) action that deals with confidentiality of mental health records. The CINA was based on the allegation that the father was grooming the daughter. At issue were the therapist’s counseling records. The father’s attorney tried to obtain the counseling records before the hearing and was denied. The therapist testified at the hearing about the sessions that were covered in the records to which access was denied. The Court of Appeals ruled that if the records were going to be the basis for testimony offered, then the father should have received access to them.

Electronic docket entries – If a person is found not guilty in a criminal case or criminal charges are dismissed, the electronic docket entries does not go away. The Court said it is a source document that is not replicated elsewhere, so those records will not be expunged. The decision also hinted at legislative action that could keep the electronic docket entries hidden so there is not public access. For example, there is an electronic record of mental health commitments, but it is now available for anyone to get online and search.

Delaware Consent Decree – The U.S. Department of Justice (DOJ) is starting to look more and more at mental health systems. A consent decree was entered with the State of Delaware that was specifically directed to their mental health system. Delaware is a much smaller state than Iowa and much more densely populated; they have a population of about 900,000 compared to 3 million in Iowa. Delaware has voluntarily agreed to some rather broad-reaching remedies:

- The State will take a central role in involuntary commitment
- Establish a crisis hotline
- Establish 24/7 mobile crisis services including a clinician, a substance abuse professional, and peer specialists
- Crisis walk-in services with access to a licensed professional 24/7
- Crisis stabilization – defined as 14 days, including prescreening and a discharge plan
- Crisis apartments that allow a 7-day stay with on-site peer specialist and on-call clinicians

- More ACT (Assertive Community Treatment) Teams showing fidelity to the Dartmouth model
- Use intensive case management and case management for people with mental health needs
- More in the area of housing, supported housing that does not mandate receipt of services as a condition of tenancy
- Provide bridge funding for deposits, rental subsidies and vouchers
- New housing must be scattered, with no more than 20% people with disabilities, private bedrooms, no more than 2 people per apartment, residents have the choice of roommates, and people cannot be rejected due to medical needs or substance abuse
- More effort in supported employment and rehabilitation
- Efforts in peer support
- Transition planning for people who are currently living in facilities
- There has to be presumption that community living is possible for all people living in facilities
- Discharge planning has to be person-centered
- The team has to start discharge planning within five days of admission
- The community provider has to meet the person
- Needs to be a peer specialist assigned to the team who has similar experience
- If a person is moved to an institution, barriers need to be identified
- A specialized transition team to help with difficult cases
- Quality and performance improvement system
- A new system of risk management that includes analysis, corrective action, and a feedback loop
- Any contracts the state enters into to accomplish these things must specify outcomes and be performance based
- There needs to be an annual review that looks at the individual, the provider, and the system wide level
- Annual report
- Governed by a monitor

Delaware's Consent Decree says that if the state fails to appropriate enough money to implement the decree, the DOJ can go back into court and nullify the decree, which would reopen negotiations.

New Hampshire Findings Letter – DOJ issued a Findings Letter on April 7, targeted to the mental health system and state hospitals. Quote: “Our findings in large measure are consistent with the state’s own conclusions and admissions about deficiencies, weaknesses, and unmet needs in the New Hampshire mental health system.” They used what the state said in their application for federal block grant funding to show the state’s deficiencies. Some of the things they identified as needs included: lack of a lower level of care that leaves people “stuck” in acute care, housing, more ACT teams, and more supported employment. In their block grant application that state said its most identified emergent needs are community residential supports for housing,

specialized housing, crisis support, increased community based psychiatric care and the development of Act teams.

The findings letter does a lot of comparison between hospital and community costs. Gretchen said some of the conclusions may be based on a false premise because most people do not stay in a hospital setting for a long period of time, so that may need closer examination. They attribute hospital admissions to a lack of community capacity and pointed to the state's own data that said about one-third of the annual admissions to the state hospital were readmitted within 180 days of discharge.

DOJ Olmstead Guidance - The federal government issued a new technical assistance document on Olmstead. A copy will be shared with Commission members. Gretchen noted that it outlines the DOJ's positions on the Olmstead community integration mandate, but that not all of them have been tested in the courts.

Virginia Findings Letter - A Virginia Findings Letter issued on February 10 focuses on some of the same areas with particular attention to discharge planning and linking people to the next step in the system.

CMH Guidance - CMS (Centers for Medicare and Medicaid) has come out with some new guidance. The Affordable Care Act changed some reporting requirements for people who are in ICFs/MR (Intermediate Care Facilities for Persons with Mental Retardation) and Nursing Facilities (NFs), so now whenever staff has a reasonable suspicion that a crime has been committed there is a short time frame for reporting it to law enforcement. For serious bodily injury they have 3 hours and for other incidents they have 24 hours, which doesn't give facilities much time to investigate before reporting and bringing in law enforcement.

Forcible Medication – The issue of forcible medication with psychotropic drugs has emerged in the Jared Loughner case. There are two viewpoints, the *Washington v. Harper* law, which says you can administer medication against a person's will with just an administrative hearing on a doctor's recommendation for dangerousness. There is also forcible medication to restore competency to stand trial and that requires a judicial hearing and there are some limits placed on it. There will probably be some new law coming out of the Loughner case.

## IMPACT OF MEPD ON MEDICAID CLAIMS

Tammie Amsbaugh presented a report on Iowa's Medicaid buy-in program for people with disabilities and its impact on Medicaid claims. Iowa's Medicaid for Employed Persons with Disabilities (MEPD) allows people with a disability to go to work and receive Medicaid coverage, either at no cost or at an affordable cost based on their earnings. The information came from a study and report done by DHS Results Based Accountability in 2009. The study compared Medicaid members as a whole with Medicaid MEPD members and looked at how employment impacts Medicaid health claims.

At the time of the study Iowa had about 357,000 Medicaid members eligible for full benefits, which included:

- 200,000 children
  - 57,000 adults
  - 30,000 aged
  - 70,000 disabled
- 
- An additional 55,000 people were receiving limited benefit programs
  - Another 15,000 children participated in Title XXI Medicaid Expansion
  - The total cost for Medicaid services was about \$230 million per month

The Medicaid buy-in program allows people with disabilities to “buy-in” to Medicaid coverage for free or at a reduced rate when access to insurance is a barrier to employment. Iowa’s MEPD Program:

- Individuals with income up to 250% of the FPL (Federal Poverty Level) are eligible.
- In the fall of 2009 there were 13,600 members.
- There are about 16,000 members now.
- Those with incomes above 150% of FPL pay a premium for coverage.
- About 24% of participants pay a premium.
- Participants must have some earned income each month.
- Income level can be modest – average is \$161/month; median is \$30/month.
- Majority are self-employed on casual jobs (child care, cleaning, chores, etc.)
- One 6% work more than 80 hours/month
- 60% work less than 10 hours/month

The study examined Medicaid claims data to determine if MEPD members have different Medicaid costs than other disabled members.

- Looked at working age adult recipients (ages 18 to 64)
- Looked at 36 months of claims (July 2007 through June 2009)
- Average claim for all recipients was \$906 per month
- Average claim for non-MEPD recipients with disabilities was \$1752 per month
- Average claim for MEPD recipients was \$526 per month

Based on this analysis, MEPD members appear to be more similar to non-disabled adult members in terms of the cost per recipient. It also appears the working positively impacts health care costs, but does not tell us why.

Does going to work reduce healthcare costs?

- Looked at claims data for about 5000 people, who met the MEPD criteria
- Looked at people before and after entering MEPD
- While recipients were on MEPD, their monthly costs were \$250 less than when they were not on MEPD

It appears that working positively impacts healthcare costs, but does not prove there is a causal relationship.

Do those who earn more have lower healthcare costs?

- Looked at MEPD members paying a premium vs. those who did not pay a premium
- Those with income over 150% of FPL pay a premium
- About 24% pay a premium

The premium-paying recipients cost the Medicaid program an average of \$65 less per month than those not paying premiums.

What about MEPD members with very low earnings?

- Looked at MEPD members earning less than \$50/month
- 61% of all members

For those with \$0 to \$50 per month income, each additional dollar earned correlated to \$1.05 less in monthly healthcare costs, but no evidence of causality.

Summary:

- Other research over the years has shown a link between work and health
- Iowa's MEPD data suggests such a link
- Although there is no clear proof that work leads to lower healthcare costs, MEPD members are costing Iowa Medicaid less than the average member
- MEPD member costs are more like those of the general working-age Medicaid population than other disabled members
- MEPD members with greater earnings appear to have lower healthcare costs
- Medicaid members who have been on and off MEPD have lower monthly healthcare costs when on MEPD than when not on MEPD

Tammie concluded by saying that it certainly appears from this data study that employment has a positive effect on healthcare costs for people with disabilities and that is important to consider in designing services and allocating resources because it adds value to activities that support employment. She added that application has been made for some supplemental funding through the MIG (Medicaid Infrastructure Grant) to do a more formal review, including a survey of members, to update the data study, and perhaps to gather more information.

Gano Whetstone commented that she had participated in the MEPD program and found it worked well, but was disappointed that rules did not allow her to continue to participate after age 65.

Tammie noted that Iowa was one of the leading states to implement an MEPD program in 2001 and that Iowa has one of the highest per capita memberships in the country. Many states are struggling with issues including the definition of work and the age 65 limitation. In response to a question, Tammie explained that individuals who are covered by SSI (State Supplemental Income) would not need to participate in the MEPD program because qualifying for SSI entitles them to Medicaid coverage. Of the 15,000 current MEPD members, Tammie noted that about 1200 are also eligible for HCBS

Waiver or Habilitation services. About 40% of MEPD participants identify themselves as a person with a mental illness.

Gary Lippe commented that people may not recognize what types of income can be counted as earnings and it may be important to prompt them to understand the broad definition of work for MEPD. Bob Bacon commented that the redesign workgroups have been charged with defining a group of core services and that this information emphasizes the importance of supported employment as a core service and looking broadly at how employment can be defined.

Tammie noted that there are also some interesting questions to consider about how expanded Medicaid eligibility under federal healthcare reform will impact the current MEPD population and what coverage will be available under the new benchmark plan.

Jack Willey expressed his thanks on behalf of the Commission to Bob Bacon and the CDD staff for hosting last month's meeting at the Center for Disabilities and Development in Iowa City. Jack commented that the experience was absolutely enlightening and an amazing opportunity. Bob responded that the day was really all about CDD's partnership with DHS and how all the projects and coordination efforts play into each other.

#### PLANNING CALENDAR

The next meeting of the MHDS Commission is scheduled for August 18 at the Orchard Place Offices in the Red Cross Building at 2116 Grand Avenue in Des Moines. Craig Wood suggested an agenda item on discussion of the Senate File 525 duties for the Commission.

#### PUBLIC COMMENT

Gano Whetstone noted that the Foster Grandparent Program she works with was honored by the Governor's Volunteer Awards for the work they do with children who have emotional, behavioral, and disability-related needs in schools.

The meeting was adjourned at 2:15 p.m.

Minutes respectfully submitted by Connie B. Fanselow.