Iowa MHDS System Redesign Final Report Executive Summary

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On October 31, 2011, the *Iowa Mental Health and Disability Services Redesign Interim Report* was issued. The Interim Report compiled recommendations made by six workgroups to redesign Iowa's mental health and disability services (MHDS) system consistent with the provisions of SF 525. The recommendations, based on Olmstead principles, were positive, thoughtful and informed. On December 9, 2011 the Iowa Department of Human Services (Department) submitted its Final Report. The Department's Final Report endorsed nearly all of the workgroups' recommendations. It also addressed areas where there was ambiguity or differences of opinion in the Interim Report, and included its recommendations for phasing in new critical core services and financing. The Final Report identifies three key areas of redesign:

- Management/Structure - Management should be provided in Regions governed primarily by county supervisors who will oversee administrative management and backroom functions.
- Services - Basic services recommended in the Interim Report will be provided locally and new critical core services should be phased-in. The basic services plus the new critical core services make up the core services of redesign.
- Financing – When the funds are available, the state should take responsibility for the non-federal share of Medicaid and provide additional general funds for growth and new critical core services.

MANAGEMENT/STRUCTURE

Medicaid dollars and services in the new MHDS system should be funded by the state and managed by the Department in coordination with Regions. The Regions should manage non-Medicaid funding and services. The Department should enter into performance-based contracts with the Regions. Locally delivered services will be person-centered, use best practices and be based on Olmstead principles.

Regional management was recommended for several reasons:

- Achieves economies of scale, reduces duplication of administration/costs and reduces inefficiencies to better use scarce resources;
- Gives rural counties the opportunity to draw on capacities of urban counties;
- Assures consistent, equitable, simplified access to a full array of core services; and
- Provides a clear locus of accountability and responsibility.

The Department made the following specific recommendations about the regional structure:

- Authority should be given to the Department to waive the targeted regional population size when meeting the parameters is not workable.

- Decisions related to the use of tax dollars should be made by elected officials. However, the Region should have flexibility to have consumer/family member and provider involvement in other decisions if they so choose.
- Regions could actually pool all county funds used to pay for services, but should be allowed to "virtually" pool county funds without actually intermingling them.
- The 5 percent administrative cap set by SF 525 should be revisited to provide a clear definition of what is included as "administrative functions" and establish the basis for the calculation. Centralization of backroom functions should be encouraged.
- Central point of coordination (CPCs) should no longer be responsible for administrative functions. In most cases, they could continue to be the local point of access for consumers and their family members and fulfill other job duties as determined by the Regions.
- Payment for services should be determined based on where a person resides. Legal settlement should be eliminated. Disputes should be resolved using existing dispute resolution process for legal settlement in Iowa Code §225C.8.
- Consumers should be allowed to appeal regional entities' decisions regarding eligibility, level of service or type of service provided. Appeals should be resolved through the Department's current appeals process with the final decision made by the Director. The Regions should be required to establish grievance processes to resolve other disputes.
- All Regions should use the same uniform cost reporting and rate setting process.

The Department recommends that Regions begin forming immediately and, in the first year of operation, focus on basic operation, creating business plans and conducting an analysis of the Region's strengths, weaknesses, opportunities, and service availability. These efforts will help guide the phase-in of new critical core services. The Department recommends the Regions begin operating by June 2013 as envisioned by SF 525 based on the following milestones:

Date	Milestone
January 2012	Regions begin to voluntarily form and at this time technical assistance will be available for those requesting it.
November 2012	DHS ensures all counties are part of a Region.
January 2013	All Regions are formed and begin to organize.
June 2013	Regions meet formation criteria.
June 2014	Regions meet implementation criteria.

SERVICES

Basic services identified by the workgroups will continue to be provided locally. In addition, new critical, core services should be phased in. All services should be provided consistently and uniformly across the state. New or expanded critical core services include:

- Health Homes - children & adults
- Crisis Services
- Sub-Acute Services
- Peer Self-Help Drop in Centers
- Employment Services
- Positive Behavior Support
- Peer Support Services
- Post Acute Neurorehabilitation for Brain Injury
- Assertive Community Treatment
- Transportation for Commitment
- Pre-Commitment Screenings

These new critical core services were selected because they provide the best return on investment. They will provide the greatest improvement in the quality of life of MHDS consumers and are most likely to reduce the use of higher end, more expensive services.

The Department recommends adopting the workgroups' eligibility recommendations with the following clarifications:

- Persons with a sole diagnosis of dementia or antisocial personality disorder should not be eligible for adult mental health services.
- The impact of adding persons with a developmental disability to the Home and Community Based Services Waiver should continue to be explored.
- The Department should explore increasing income eligibility from 150 percent to 200 percent of the Federal Poverty Level if the Affordable Care Act is implemented.
- The following assessment tools should be utilized beginning July 1, 2012:
  - Supports Intensity Scale (SIS) for persons with intellectual disabilities;
  - LOCUS for persons with chronic mental illness; and
  - Uniform Brain Injury assessment process and tool.
- Providers of non-Medicaid services should be allowed to waive co-payments if the provider is able to fully absorb the cost.

The Department made the following recommendations regarding outcome and performance measures:

- A Performance Measures Workgroup should be established to develop a set of person-centered performance outcome measures.
- The Department should begin publishing preliminary performance outcome measures using current data by the end of FY 2012.
- A Service System Data and Statistical Information Integration Workgroup should begin in January 2012.
- All performance data should be submitted to the Department and should then be shared with the Regions, providers, Legislature, and public.

The Department made the following recommendations regarding workforce development:

- The Legislature should establish a MHDS Workforce Development Workgroup beginning in July 2012 to develop strategies to address workforce shortages.
- The following improved workforce practices should be undertaken statewide:
  - Expand the use of peer provided services;
  - Increase and improve peer service training; and
  - Expand the use of the College of Direct Supports.

FINANCING

Iowa has a highly complex system for financing MHDS. The Department's recommendations are designed to preserve funding for non-Medicaid funded services, simplify the system, eliminate unnecessary "transactional friction," and improve overall fiscal accountability.

What is the problem?

Current projections for MHDS financing, shown below, estimate that the amount of funding available for non-Medicaid services is expected to drop by $56M in FY 2013. This is made worse because the demand to fund Medicaid is projected to exhaust the counties' remaining fund balance.

	FY 2012	FY 2013	Difference
Medicaid/Resource Center	$216,865,613	$231,038,178	$14,172,565
Non-Medicaid	$143,523,075	$87,563,560	-($55,95,515)
Total	$360,388,688	$318,601,738	-($41,786,950)

Counties are first required to provide their share of non-federal Medicaid match. The amount of funds remaining is what is available to serve persons who are not Medicaid eligible or to provide services that are not Medicaid reimbursable. The increased demand for Medicaid funding is dramatically reducing the amount available for non-Medicaid services. If this remains unaddressed, persons who are not Medicaid eligible and non-Medicaid funded services would need to be reduced significantly. This would primarily affect persons with mental illness.

In addition, the current system requires the state to send $171M to the counties and the counties turnaround and send the funds back to the state to cover the non-federal share of Medicaid for certain Medicaid programs provided to persons with legal settlement. The Department pays the non-federal share of Medicaid for other types of MHDS and for persons without legal settlement. The Department also funds non-Medicaid services for persons without legal settlement. This approach is unnecessarily complex, administratively inefficient and lacks accountability.

What do we propose to do?

The Department proposes the following to address the impending shortfall in non-Medicaid funding and greatly simplify the current MHDS funding system:

- The state assumes the non-federal share of Medicaid when funds are available.
- The $122 to $125M currently allocated from the county property tax levy should stay in the system to address non-Medicaid services. This can be done either through maintaining the property tax levy or through an infusion of state money.
- Growth in both the Medicaid and non-Medicaid services should be funded.
- New critical core services should be phased-in.
- Savings should be achieved by adopting strategies such as the Balancing Initiative Program and the Affordable Care Act, if implemented.

The Department's proposal funds non-Medicaid services close to previous levels, protects non-Medicaid funding from being eroded by Medicaid growth, greatly simplifies the funding system, and allows Regions to use administrative savings for services.

The total cost for these changes is shown below.

PROPOSED STATE GENERAL FUND INCREASE					
Amounts in Millions	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Net Increase from FY 2013	$42	$69	$101	$121	$133
Year to Year Increase	$42	$27	$32	$21	$12

The Department recommends these changes to be done thoughtfully, respectfully and methodically within the recommended timeframe while assuring services are not disrupted.

Appendix 1: Summary of Financial Roadmap

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

Totals may not add due to rounding.

Appendix 2: Estimated General Fund Impact of Phased-In Plan (In Millions)

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