

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION  
February 16, 2012, 9:30 am to 3:00 pm  
Altoona Public Library  
700 8th Street S.W., Altoona, IA  
MEETING MINUTES

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MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick	David Hudson
Lynn Crannell	Linda Langston
Richard Crouch	Zvia McCormick
Lynn Grobe	Laurel Phipps
Jan Heikes	Gano Whetstone
Richard Heitmann	Jack Willey
Chris Hoffman	Craig Wood

MHDS COMMISSION MEMBERS ABSENT:

Senator Merlin Bartz	Cindy Kaestner
Senator Jack Hatch	Gary Lippe
Representative Dave Heaton	Susan Koch-Seehase
Representative Lisa Heddens	Dale Todd

OTHER ATTENDEES:

Pam Alger	DHS, Targeted Case Management
Theresa Armstrong	DHS, MHDS, Community Services & Planning
Rhonda Bennett	Iowa Department of Inspections and Appeals
Teresa Bomhoff	Iowa Mental Health Planning & Advisory Council
Kenneth Briggs	Iowa Mental Health Planning & Advisory Council
Diane Diamond	DHS, Targeted Case Management
Connie Fanselow	DHS, MHDS, Community Services & Planning
Mark Hanson	Iowa Assn. of Area Agencies on Aging/Dallas County
Julie Jetter	DHS, MHDS, Community Services & Planning
Laura Larkin	DHS, MHDS, Community Services & Planning
Jerry Mayes	Olmstead Consumer Task Force
Liz O'Hara	U of Iowa, Center for Disabilities & Development
Eric Preuss	Iowa Department of Public Health
Natasha Retz	Brain Injury Association of Iowa
Donna Richard-Langer	Iowa Mental Health Planning Council
Ann Riley	U of Iowa, Center for Disabilities & Development
Joe Sample	Iowa Department on Aging
Rick Shults	Administrator, DHS Division of MHDS
Deb Eckerman Slack	ISAC County Case Management Services
Heidi Smith	Lutheran Services in Iowa
Marissa Eyanson	Easter Seals Iowa

OTHER ATTENDEES (continued):

Daniel Van Sant	Disability Rights Iowa
Deb Westvold	CDD/DHS, Targeted Case Management
Robyn Wilson	DHS, MHDS, Community Services & Planning

WELCOME AND CALL TO ORDER

Chair Jack Willey called the meeting to order at 9:40 a.m. Quorum was established. Jack led introductions of Commission members and guests. No conflicts of interest were declared for this meeting.

APPROVAL OF MINUTES

Lynn Grobe made a motion to approve the January 19, 2012 meeting minutes as presented. Laurel Phipps seconded the motion. The motion passed unanimously.

MHDS UPDATE

Theresa Armstrong shared an update on MHDS Division activities:

Family-to-Family Iowa's Family Navigator Program is a cooperative network including providers, Child Health Specialty Clinics, and other organizations that are working with DHS to provide family navigators to families of children with developmental disabilities. The goal of the navigators is to be on the frontline and assist families in finding where to go, who to contact, and, when needed, also offer more in-depth support. The project is funded under a federal grant, which is now in its third year. There are currently 46 trained navigators throughout the State, who are all parents and family members of individuals with disabilities.

The project has a governance group made up of representatives from the organizations involved. It includes, ASK Resource Center, the Arc, Community Circle of Care, and other agencies. Child Health Specialty Clinics has a grant that funds a few new navigators, but there is also a commitment on the part of the member agencies that were already providing some kind of family support that they will train their existing staff people to be part of the network. The goal for this year is for 3400 families to receive some kind of "casual" assistance, such as a phone call or email to answer specific questions. About 660 families will also receive more in-depth or comprehensive services.

Since this is a federal contract, there are specific outcomes that are being tracked, such as:

- Is my life better?
- Is my child's life better?
- Am I able to link to the educational resources I need?
- Am I able to link to the community resources and services I need?

Responses are showing a significant improvement in the outcomes reported by families. This is another resource that can be built upon as the Redesign moves forward.

Systems of Care for Linn and Cerro Gordo Counties – Last year, the Legislature appropriated \$160,000 for a systems of care project for Linn and Cerro Gordo counties. After an RFP (Request for Proposals) process, the contract has been awarded to Four Oaks and will probably begin in March. The contract with Four Oaks will begin this fiscal year, with the intent of continuing it into the next fiscal year. The focus is going to be on children within the Four Oaks PMIC (Psychiatric Medical Institution for Children) program and on the waiting list for the PMIC program, as well as reaching out to communities to serve children in alternative ways. In cooperation with the other systems of care projects, they will also be working to develop ways to get children who are placed out of state back into their communities or closer to home through a systems of care “wrap-around” approach.

Emergency and Crisis Services – We have previously reported on the provision of disaster mental health services to the counties on the western side of the state that were affected by the flooding last summer. That was the initial services phase. The Department also applied for a longer term grant contract that will run for about a year, which has been awarded. Services will continue in those western counties under the grant. The two providers in that area and the Iowa Concern Hotline have had one-on-one or direct contact with almost 3000 people – more than 6 times the 477 people they had projected. They have also engaged in community education and helped people learn about and connect with resources in their communities that can help them.

## MHDS REDESIGN

Rick Shults shared an update on MHDS Redesign activities. Bills have been introduced in both legislative chambers. There are three different bills that deal with various aspects of redesign. All three were introduced in identical form in both the House and Senate. The three bills are:

- The “large policy” bill
- The change in MR terminology bill
- The recommendations from the Judicial workgroup

### Policy Bill:

Eligibility - The “large policy” bill contains the policy changes related to the redesign of the system. It includes the codified recommendations related to eligibility based on income, age, and diagnosis, and addresses eligibility in several ways, scattered throughout the bill:

1. Provisions for eligibility related to income
  - a. Continuation of eligibility of up to 150% of the FPL (federal poverty level), to be revisited when the ACA (Affordable Care Act) goes into effect, January 1, 2014.
  - b. Allows co-pays for services for people under 150% FPL.

- c. Allows co-pays for people over 150% FPL and it is assumed there would be co-pay for that group.
- d. Adult eligibility begins at age 18.
- e. Disabilities covered include intellectual disability, brain injury, and mental illness. The mental illness definition includes most diagnoses except for the sole diagnosis of substance abuse, the sole diagnosis of intellectual disability, dementia, and a variety of “V” codes identified in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition).

Rick said the Department’s recommendation would be to unify all the eligibility requirements into one section. The final piece is eligibility for scope of services; there is still need to clarify the application and use of specific functional assessment instruments to be used for determining the scope, duration, and frequency of services for an individual. There has been a recommendation to use the SIS (Supports Intensity Scale) for individuals with intellectual disabilities, the LOCUS (Level of Care Utilization System) for persons with mental illness, and no specific tool has yet been identified for use with individuals who have brain injury. In response to a question, Rick indicated that including in the law which specific assessment tools should be used is probably not necessary. That may be something that changes over time and the suggestion would be to place that in rule or policy rather than statute. The bills as currently written identify the specific tools and legislators will have to decide if they want to change that.

Core Services – Each of the workgroups went about identifying core services in a different way, which presented a challenge for the bill drafters. The Mental Health Services group made very specific recommendations and those coming out of the Intellectual Disabilities Services Workgroup were fairly vague. The legislators adopted an amendment in their Interim Committee to list more specific types of services for persons with ID. There will likely be more input from other sources. The language should be specific, yet maintain enough flexibility for new services to be identified and added. Rick noted that what needs to be addressed is more organizational than substantive.

Residency – The bills call for the shift from legal settlement to county of residency. The Interim Committee heard some recommendations from the Attorney General’s Office; three clarifications were identified for inclusion in the county of residence definition:

- The area that is responsible for an individual is the area that serves the county in which the person resides.
- An individual cannot establish residency if they move to an area for the purpose of accessing services.
- A dispute resolution process was added.

The AG’s Office also recommends that the language be clear and explicit that when a person goes to another area of the state to temporarily receive services, such as a person going into facility for inpatient psychiatric services, they retain their last residency.

Other suggested clarifications:

- The area where the person presents themselves is the area that is responsible for securing and maintaining services.
- The area where the person resides is the area that is financially responsible.

Rick indicated there was considerable discussion about whether this goes far enough. If the state is able to take over the financial responsibility for Medicaid, the challenge remaining would be that the regions will be responsible for the administration, management, and payment of non-Medicaid services and it would still need to be determined what region is responsible for a particular individual.

Rick said that a significant number of issues have been eliminated. Any time requirement for a person to live in a place, whether or not they have received services, has been eliminated. Under legal settlement a person had to live in a new place for a year without receiving services for their county of legal settlement to change. This removes any historical component.

Craig Wood commented that the concept of residency expressed is much simpler than legal settlement and that unless the State is paying for all services, there needs to be some residency basis to determine how county property tax dollars in the system will be used. Without that, a region with a State Resource Center, MHI, or other large facility would end up paying for everyone who comes there. Rick indicated that the question of people coming from another state to Iowa for services is not explicitly addressed unless they have intent to become a resident. He said that will need to be sorted out, but likely those people would become a State responsibility.

Regions - The bill essentially adopted the list of what establishes a region that came out of the workgroup. Some of the recommendations were exhaustive and may need to be condensed or made more generalized. The current proposal calls for regions to be identified by July 1, 2013 and fully functional by July 1, 2014.

Craig Wood commented that the legislature must address what happens to assets and debts when counties join regions, as well as how disputed billings between counties and Medicaid will be handled and how county fund balances will figure into the regions. Rick said Director Palmer asked ISAC (Iowa State Association of Counties) just yesterday to make a list of those questions to be worked through. He said he thinks many can be addressed without making Code changes and some of that may be dealt with through the 28E agreements.

Rick noted that the CSS (Community Social Services) region leadership made a presentation to the legislative Interim Committee a few weeks ago. The CSS auditor identified specific examples of significant efficiencies in consolidating business practices. He said he wants to stress that regionalization is about the business functions of the system, and there is a commitment to retain local access (local point of entry) for the users of the system - regional administration and local delivery. There was also a presentation yesterday from ISAC on the CSN (Community Service

Network). CSN is a result of counties working together to create a better data and billing system and an example of the kind of efficiencies we could continue to see in a regional system.

Linda Langston commented that changing to CSN will cost more for some large counties that have developed their own systems. She said Linn would have to hire more staff to do the same thing on CSN they do on their own system now, so it would not be a cost savings for them. It was noted that all counties except Polk, Linn, Johnson, and Scott now have CSN and it has been a valuable system especially for small counties.

Workgroups - The bill also establishes workgroups:

- Workforce
- Coordinating among agencies (Senate File 525)
- Outcome measures (Senate File 525)

DHS Suggestions focus mostly around the organization of the bill: There is a significant amount of the bill that is written under the home rule section and there are probably some pieces of that that belong in Chapter 225C (the mental health and disability services code). DHS has suggested some clarification of roles there, including:

- Clarifying that MHDS will have contract authority with the regions
- Improving the organization of the provisions and condensing some of the Code, such as the regional service plan provisions

Terminology Bill:

The second bill changes the use of the term mental retardation to intellectual disability throughout Iowa Code. It has been passed by committee to the House and is being considered by the Senate today. There will be one reference to MR remaining in the Code because the term is still a definition used in the DSM IV and federal regulations still use terms such as ICF/MR. Those references can be changed when the other sources are changed, but it is important to make sure that the language change causes no unintended consequences.

Judicial Workgroup Recommendations Bill:

The third bill contains the recommendations made by the Judicial Workgroup, including:

- Requirement that law enforcement officers have 12 hours of training in mental illness every three years.
- Changes in the definition of mental health professional.
- Authorizes prescreening for commitment.
- Continues the workgroup for another year.

There was an excellent discussion in the House yesterday about how many hours of training law enforcement officers need to have. Time and cost are issues. It was noted that 12 hours of Mental Health First Aid training are offered for only \$25.

In response to a question, Rick noted that the Governor's Budget includes beginning some key pieces of Redesign a year earlier than Senate File 525 anticipated, including:

- Reducing the counties' obligation for Medicaid
- Funding to pay for the process of screening
- Identifying the establishment of health homes for children, with a focus on bringing children back to Iowa from out of state placements
- Providing technical assistance to regions

BIPP - Another part of the overall State strategy is to balance expenditures between institutional and non-institutional spending. That includes applying for the Balancing Incentives Payment Program (BIPP) which is a federal funding opportunity that is part of the Affordable Care Act. The Governor's Budget included additional federal funds from the BIP Program to use in Redesign efforts.

The House bill will be introduced as an appropriations bill, so it is exempt from the funnel. The most important thing that makes it an appropriations bill is the reinstatement of property tax authority, possibly coupled with a plan to buy county tax participation down over about five years with the understanding that if the State did not meet that commitment, the property tax component would remain in place. There is an understanding by the legislators that are close to this that the system cannot afford to lose the \$125 million that comes from property tax dollars. That money is needed to cover non-Medicaid services. On the Senate side, the interest is in reestablishing the property tax authority and keeping county tax dollars in the system, rather than pursuing a buy-down.

It appears that the principles of regionalization, services, and the broad principles of financing the Redesign are very consistent in the House and Senate and the differences come down to how it is going to be funded; that probably won't be decided until the very end of session.

Jack Willey commented that last week at the ISAC Supervisor's Affiliate meeting, where the finances will come from was a major topic of discussion. There has been skepticism expressed that the State will actually follow through and take over all those costs. Many remember when a similar commitment to increase state funding was made in Senate File 69, but State funding was not increased as planned and counties left without the ability to raise more revenue themselves. Jack shared copies of what ISAC is proposing. He said supervisors were relieved to hear that the local CPC contact function would continue in a regional system.

Linda Langston commented that there needs to be an understanding how the balancing is going to happen in forming regions because there are a significant number of counties now in deficit. Levy rates are substantially different from county to county and there is a lot of concern about how all that will be balanced out. She said she is also concerned that because of the current budget situation, by next year Linn County will have dismantled many programs that will be required under Redesign, and it will be very inefficient to cut them now and bring them back in a year or two.

Richard Crouch voiced concerns about the size of regions, indicating that in western Iowa it might take as many as 25 counties to get to 200,000 minimum population size. Jack Willey commented that in the southern tier of Iowa it may also be difficult for regions to associate with the required resources such as FQHCs (Federally Qualified Health Centers).

Jack Willey noted that on Saturday morning, February 18, Senator Jack Hatch will hold a listening post meeting in Room 201 at Cowles Library on the Drake University Campus and encouraged members and others to attend.

## PUBLIC COMMENT

Mark Hansen shared a handout outlining the Iowa Association of Area Agencies on Aging's 2012 Advocacy Priorities and commented that the aging community is also engaged in issue discussions about regions, as the AAAs are undergoing a reorganization which reduces their numbers from 13 to 5.

Jerry Mayes announced that he has stepped back from some of his advocacy group and federal review duties for health reasons and wanted to express his thanks to everyone who has worked with him in advocacy efforts over the last 10 years, including the Commission, the Olmstead Consumer Task Force, and the Mental Health Planning Council. He said he wants to wish everyone the best and has high hopes for the Redesign effort. On behalf of the Commission, Jack Willey thanked Jerry for his hard work, participation, and friendship and for sharing his vast array of knowledge.

A lunch break was taken at 11:30 p.m.

The meeting resumed at 12:45 p.m.

## BALANCING INCENTIVES PAYMENT PROGRAM (BIPP)

Theresa Armstrong shared information about the Balancing Incentives Payment Program, which is a federal CMS (Centers for Medicare and Medicaid) opportunity for states to apply for funding to balance out their institutional costs with their home and community based services costs. CDD (Center for Disabilities and Development) has been working with MHDS in preparing for Iowa's application. Debbie Johnson from IME has also been working closely with MHDS on the application. The "balancing" is in terms of state spending, not numbers of beds. Right now Iowa is spending about 56% on institutional services and 44% on community based services and has been moving in the direction of more community based spending.

In response to a question, Theresa noted that the term "institutions" include:

- Nursing facilities (NFs)
- Intermediate Care Facilities for Persons with MR and related conditions (ICFs/MR)
- Psychiatric Medical Institutions for Children (PMICs)

- Nursing facilities for Persons with Mental Illness (NFMIs)
- Psychiatric inpatient treatment

To apply for BIPP, an application has to be completed and submitted to CMS; CMS then has 60 days to respond. The DHS goal is to have Iowa's application in by April because the Governor's Budget for FY 2013 includes cost savings of \$11 million from BIPP. The cost savings would come from a 2% increase in FMAP (the Federal Medical Assistance Percentage), which means the federal government would pay 2% of the cost of Medicaid for the program. The increase would potentially be from September 2011 to September 2015.

BIPP requires states to use:

1. A single point of entry/no wrong door concept – to make access very fluid for individuals
2. A standard assessment – meaning a single assessment used for each particular disability type (For example: SIS (Supports Intensity Scale) for persons with intellectual disabilities, LOCUS (Level of Care Utilization System) for persons with mental illness, and another type to be determined for persons with brain injury)
3. Conflict-free case management

Theresa indicated there is still more to learn about what conflict-free case management means. The best current understanding is that the case manager should not be employed by the agency providing the service, eligibility determinations should be separated from the service provider, and case managers should not determine funding. It is possible to set up "firewalls" where there is a potential for conflict, to create different administrative reporting lines, and other quality assurance checks. It may not always be possible in a small community for case managers and service providers to be completely separate, but safeguards can be put into place to make that work. Administrative separation could be established. One idea of a "firewall" would be to have an advocate for the consumer in the room when service decisions are being made as an assurance that the consumer is presented with choices. Consumer choice will have to be documented. Theresa noted that CMS will review the safeguards that Iowa proposes to put in place as part of the process and will let us know if they approve. It is still very much a learning process.

MHDS is in the process of developing a preliminary work plan to set out what things Iowa plans to do. The finalized work plan is not required to be in place until 6 months after approval of the state's application. Theresa noted that no state applications have been approved by CMS yet so we are early in the process. DHS hopes to have their application approved before July 1.

Zvia McCormick commented that other states have had conflict free case management in place for many years and we may be able to learn from their real life experience as well as from the federal technical assistance available.

## HEALTH HOMES/SYSTEMS OF CARE

Laura Larkin spoke to the Commission on the concept of health homes and systems of care. She shared a handout on health homes created by IME that was used by the Children's Workgroup last summer. Currently there are two systems of care projects operating in Iowa – the Community Circle of Care (CCC) covering ten counties in northeast Iowa and the Central Iowa System of Care operating in Polk and Warren Counties. The workgroups that met last summer and fall recommended that Iowa goes to a statewide system of care for children's services. A third system of care project will be beginning soon in Linn and Cerro Gordo Counties.

Laura also shared the DHS Implementation Report regarding the Mental Health Services System for Children, Youth, and their Families, presented to Legislature in January. The report lists service gaps identified by the workgroups. They include:

1. No clear points of accountability or organizing entities
2. No logical pathways for access to treatment
3. Child-serving systems are disconnected
4. Over-reliance on Medicaid as the first or sole funder of services
5. Children receive services based on availability of services rather than need
6. Needs of parents, guardians, caretakers, and family members are not adequately addressed
7. Residential and PMIC services are not providing optimal impact due to their disconnect from community-based services and insufficient care management
8. Lack of timely access to key individual services leads to delays in care, potential harm, and increased utilization of out of home and out of state treatment options
9. Statewide access to crisis intervention and brief stabilization or intervention services are needed
10. Transition planning for persons going in and out of institutional settings is insufficient
11. Insufficient focus on health promotion
12. Insufficient focus on prevention and early identification of needs
13. Transition-age youth are underserved by both the child and adult systems
14. Education supports are inconsistently available and not sufficiently coordinated with treatment services
15. Providers need expanded ability to manage needs and behaviors in the state

The full report is available at:

<http://www.dhs.state.ia.us/Partners/Reports/LegislativeReports/LegisReports.html>

The report also identifies the components of a system of care that are considered critical to the support of children with, or at risk of serious emotional disturbance or other disabilities, and their families:

1. No wrong door – a centralized access point for information, services and supports, assessment and evaluation that families can easily recognize when they look for assistance

2. Individualized service planning – family and youth-driven planning and care coordination that involves children in the process and supports them in leading the planning for what they need. That also includes helping families make the connections to develop natural supports rather than becoming more dependent on the system and be successful without a lot of external intervention.
3. Coordinated community-based supports – a coordinated network of flexible community-based supports and options for more than one provider whenever possible
4. Flexible funding – to help families access services and supports that aren't available through Medicaid, private insurance, or other commonly utilized funding sources. Experience in the current system of care projects has shown that small investments in getting families what they need can lead to great cost savings.

Parent involvement is central to the philosophy of systems of care for children, so sometimes extra effort is necessary to engage and support the family members as well as the child.

The Community Circle of Care federal funding from SAMHSA (Substance Abuse and Mental Health Services Administration) ends September 30 of this year. DHS has requested \$1.4 million in state funding to continue the CCC project for SFY (State Fiscal Year) 2013, and \$328,000 to maintain the Central Iowa System of Care project through SFY 2013. Laura noted that as the Children's Mental Health Waiver has expanded, children can be moved over to the Waiver to receive long term services. More children may be able to be served through health homes. The process for how systems of care and health homes can be rolled out to the rest of the State of Iowa is still under development.

Theresa Armstrong noted that the Governor's Budget contains \$500,000 to start on the development of health homes for children. If we establish health homes for children who are eligible for Medicaid, there are components that can be billed to Medicaid with a 90% federal match, so that is one way to maximize Medicaid dollars to help make the model sustainable.

The new systems of care (SOC) project starting will be starting in Linn and Cerro Gordo counties in next few months. DHS issued a request for proposals (RFP) and the contract was awarded to Four Oaks. Four Oaks has a history with PMICs, so this is an opportunity to bring the SOC concept into PMICs to help families learn about other options that might be available to them and to use the SOC as an alternative to PMIC admission when appropriate. Families often go to a PMIC because they don't know where else to go. A system of care can help get them connected and keep them connected and may divert children before they are admitted to a PMIC. We know that children are best supported in their homes, communities, and schools.

Laura shared a handout on the Children's Mental Health Home Concept, indicating that IME (Iowa Medicaid Enterprise) is in the process of working with CMS to submit an application to provide health homes in Iowa. The handout shows a 3-level pyramid:

Level 1 – (lowest level) Children with a single chronic MH diagnosis and minor functional impairments, which would represent the simplest to serve and the largest number of children.

Level 2 – (middle level) Children with a diagnosis of Serious Emotional Disorder (SED), which would represent a little more complexity and a smaller number of children.

Level 3 – (upper level) Children with multiple diagnoses, multi-system involvement, major functional impairments, high risk and complex needs, which would represent the smallest number of children with the highest level of complexity.

The children who are represented in Level 2 and 3 of the pyramid are the children who are now being served by the current systems of care projects. It is important to work for more early intervention; more children should be seen at Level 1 and getting what they need so they do not progress to a higher level. Laura noted that a lot of basic mental health training has been done with teachers, staff, and administrators in schools so they can recognize signs and symptoms of depression, anxiety, and suicidal behavior, and know how to intervene in a crisis. IME is hoping to submit its application soon and be able to start implementing health homes on July 1.

Jack Willey indicated that any specific suggestions or concerns about Redesign should be communicated them to Rick Shults or Theresa Armstrong.

David Hudson asked if any more information was available related to the discussion from an earlier meeting about the property tax relief funding issue. Craig responded that the DOM (Department of Management) informed county auditors that they will have the ability to increase their property tax levy based on the reduction of property tax relief, so that issue has been addressed as far as the cuts are concerned. Craig commented he is still concerned that the current law will need to be changed this session if the Governor's Budget is to make use of the whole \$88 million that is identified for property tax relief. Craig noted that the Commission wrote a letter to the Legislative Interim Committee on the funding issues. Craig and Neil went to a committee meeting and the presented letter to members.

## PUBLIC COMMENT

Teresa Bomhoff commented that the same basic set of legislative priorities has been endorsed by NAMI (National Alliance on Mental Illness), the Mental Health Planning Council, and AMOS (A Mid-Iowa Organizing Strategy). IDAN (Iowa Disability Advocates Network) and the Iowa Human Needs Advocates are also supporting something similar. The message to the Legislature should be that all the groups' basic priorities are the same.

Attachment #2

Liz O'Hara noted that BIPP allows states until September 2015 to have all their changes in place, which gives us some time to coordinate those system changes with Redesign.

Tasha Retz announced that the Brain Injury Association is holding its Legislative Day on February 28.

The meeting was adjourned at 2:00 p.m.

Minutes respectfully submitted by Connie B. Fanselow.