

**THE IOWA ALLIANCE OF COMMUNITY MENTAL HEALTH CENTERS**  
**RECOMMENDATIONS TO THE IOWA GENERAL ASSEMBLY**  
**CONCERNING MENTAL HEALTH AND DISABILITY SERVICES SYSTEM REDESIGN PRELIMINARY**  
**DRAFT LEGISLATION RELEASED JANUARY 26, 2012**  
**February 1, 2012**

**ABOUT THIS COMMENTARY #3**

The Iowa Alliance of Community Mental Health Centers (the Alliance), with 19 members, represents over half of such Centers accredited, or deemed to be, by the State of Iowa. They serve as the safety net provider for the majority of those with serious mental illnesses in our State. Alliance members (*see footnote*) primarily deliver child, adolescent, adult and family mental health services, and often substance abuse treatment, across most of Iowa's 99 counties that include two-thirds of the state's population.

This is the third in a series of Alliance commentaries addressing the general challenges and specific issues confronting Iowa's public policy makers as they undertake to redesign a major component of this state's public and private health care delivery systems. Commentaries #1 and #2 were issued in the course of the deliberations of work groups constituted by the Department of Human Services (DHS) and the meetings of the Mental Health and Disability Services Study Committee. Summaries of those two documents can be made available to the reader.

Commentary #3 is a critique of the first preliminary draft of redesign legislation prepared in response of direction provided by the legislative interim study committee and released January 26, 2012. The Alliance has characterized its comments as Action Items, Questions, and Comments and these are arranged in a page and line format to facilitate study. We commend LSA and involved legislators in providing a good starting point in drafting this important legislation. That said, we continue to believe that funding issues should be addressed sooner than later.

The study committee also released a judicial commitment draft but the lack of time to adequately review that draft precludes inclusion of comments on it in this Commentary #3. Those comments will be forthcoming.

Blackhawk Grundy CMHC, Waterloo  
Southern Iowa MHC, Ottumwa  
Richmond Center, Ames  
Vera French MHC, Davenport  
Berryhill Center for MH, Ft. Dodge  
Mideast Iowa MHC, Iowa City  
Plains Area MHC, LeMars  
North Iowa MHC, Mason City  
Abbe Center, Cedar Rapids  
Poweshiek Co. MHC, Grinnell

MH Clinic of Tama County, Toledo  
Northeast Iowa Behavioral Health, Decorah  
EyerBall CMHC, Des Moines  
Center Associates, Marshalltown  
Seasons Center for CMHC, Spencer  
West Iowa CMHC, Denison  
Orchard Place/Child Guidance Center CMHC, Des Moines  
Community Health Centers of Southern Iowa, Leon  
Waubonsie MHC, Clarinda

Page 1, line 8: **ACTION ITEM-- Strike “level of care utilization system”**. *Rationale* – LOCUS, or any other specific functional assessment tool, should not be put into the Iowa Code but rather retain the general reference to a standardized functional assessment methodology approved by the commission through administrative rule making as stated in lines 10-12. This is an Action Item applicable to several other references in this draft. See appropriate language on Page 8, lines 6-9 regarding brain injury assessments. This methodology should be uniform throughout the state and not with different assessment tools adopted on a county-by-county or region-by-region basis.

Page 1, line 35: **ACTION ITEM -- Add “department director” to list of those required to approve a regional management plan**. *Rationale*—The director today must approve county management plans and as the person most accountable for the system the director should have this authority.

Page 2, line 6: **QUESTION -- Why should each county have a unique service system management plan? Doesn't this just perpetuate the same fragmented system we have today?**

Page 4, line 8: **ACTION ITEM – Strike “if the region contracts with a private entity.”** *Rationale* – If the region is managed by the counties rather than a private entity, it should be subject to the same risk management and fiscal viability standards as a private business.

Page 5, line 14: **COMMENT** – This line is inconsistent with Page 1, line 35 which does not give the director this authority. As noted above, we support granting the director that authority.

Page 5, line 33: **ACTION ITEM – Insert the following “...the region may not apply a copayment requirement for a particular service...”** *Rationale*: We believe very strongly that chasing these very small amounts as applied to those earning less than 150% of FPL is an unwise use of resources, penalizes those least able to afford a co-pay, and only draws criticism from the uninformed when these “receivables” grow in amount.

Page 6, line 6: **COMMENT** – This is where the commission is given the authority to allow a sliding fee schedule for those earning above the 150% FPL. We support this specific statutory grant of such authority.

Page 6, line 24-27: **COMMENT** – This list is too restrictive as other more useful assets could be disregarded to access non-federal funded services. These exempt assets could include an auto of a certain value, a small savings account or a home up to a certain value. There are other categories.

Page 6, line 35: **QUESTION** – What is the rationale for the 18 year old threshold? Does every child have a funding option besides the county? What about children with no insurance?

Page 7, lines 2-4: **ACTION ITEM – Delete this sentence**. *Rationale* – This sentence states that the only way for a person to receive services (and the provider to be paid for providing the

service) is for the person to have “during the preceding twelve-month period a diagnosable mental health, behavioral, or emotional disorder.” What happens if a person presents, is given an assessment, and is found to not have one of those disorders? Should the provider be denied payment for conducting the assessment? That would be akin to allowing a person to refuse to pay a dentist if he/she has a checkup and the dentist finds no cavities? What if the cause of the symptoms presented is a physical ailment? Or what if a medical doctor has referred a person for assessment in order to exclude certain physical illness diagnoses that the doctor might otherwise consider treating? How does one become eligible for funding if the first appointment at a CMHC is to determine the diagnosis? It is ambiguous and unnecessary.

Page 7, line 13-18: **ACTION ITEM – Delete sub-section d. and insert “The person’s eligibility for individualized services shall be determined by a standardized functional assessment methodology approved for this purpose by the state commission.”** *Rationale --* See comments for Page 1, line 8. See also Page 8, lines 6-9.

Page 7, lines 28-32: **ACTION ITEM – Delete sub-section d. and rewrite the section.** *Rationale –* See comments for Page 1, line 8. See also Page 8, lines 6-9.

Page 8, lines 21-32: **QUESTION and COMMENT –** As a general proposition we are uncertain how some of these services can be provided within a region without some direct support and collaboration by one or more state agencies. We recognize the need for the qualifier “subject to the availability of funding” but ask the question of when, how, and by whom this availability or lack thereof is to be determined?

Page 9, line 20: **COMMENT –** The term “evidence base” has come into vogue as a descriptor for an accountability tool intended to prevent use of untried or tested theories of diagnosis and treatment. We would caution against its use in this context as being perhaps too restrictive. Consideration should be given to “promising practices,” “emerging practices,” or “evidence informed practices,” or other broader professionally recognized standard(s).

Page 10, lines 26 and following, Sec. 7 Regional service system financing: **COMMENT –** Neither in Sec 2, Regional Service system management plan nor in this Sec. 7 (or elsewhere in the bill for that matter) is there any requirement that a region’s annual budget (fiscal plan) must be approved by anyone beyond the regional governance board. This is either an unintended oversight or it is to be found elsewhere in current law or the conforming amendments. All Sec. 7 provides is that it is “a fixed budget amount.” The bill draft does require that it be in the regional service plan and budget and there are provisions that a county plan must be approved by the commission. We recommend that the budget also be approved by the department director. At the very least this should be clearly stated and all doubt removed that a region’s plan, including its annual budget, must be approved at the state level.

Page 11, lines 6-7: **COMMENT –** We are uncertain that the commission will have the fiscal analysis resources to undertake the analysis needed to develop an allowable growth factor. The Legislative Services Agency has great experience in doing this analysis but the executive

branch may be uncomfortable delegating this task to the legislative branch. If not the LSA then the Department of Management should be involved in this analysis.

Page 12, line 5, Sec. 11, Mental health and disability services workforce development workgroup: **COMMENT and QUESTION** – We have supported the creation of this workgroup since it was first suggested during the interim workgroup process. The reasons have been stated well and repeatedly. However, we do have a concern based on past experience. The legislature has often used this mode of policy research and analysis. However, the legislature has often under-funded the effort resulting in less than satisfactory results. This particular workgroup is proposed to have 23+ members with an agenda subject that ranks as one of the most chronically controversial in the public policy making arena. The tasks are extensive and require great technical expertise. The end product will arguably be picking winners and losers within the treatment services provider communities.

All this is to say that moral and fiscal support from the most senior levels in the executive and legislative branches and involve commitment that must be obvious to all the stakeholders. Timely success in this area is nothing short of a good economic development strategy with an enormous impact on the well-being of our citizens. On the other hand, failure in this critical area will kill whatever momentum is generated by the enthusiasm of the initial success in launching this redesign. Make the necessary resources available so this task has an opportunity for success. It is a good short and long term investment.

Page 12, line 35: **ACTION ITEM – Delete sub-paragraph i. and insert NEW SECTION. i. A representative of a community mental health center, a representative of a federally qualified health center, a representative of a hospital with an inpatient psychiatric unit, a representative of a state mental health institute, and at least three other providers of mental health and disability services.** *Rationale* – Recognizing the value of the numerous public members on this workgroup, in the end it is the health care providers that seek to employ the individuals this work group seeks to find, train, and place throughout the state. These providers need to be well represented. The named providers are all specifically named as a mandatory presence in every region. Their value should be recognized by being specially named to this workgroup. They are all “boots on the ground” now and their expertise and incentive for this effort to succeed is, in the words of Madison Avenue, “priceless.”

Page 14, lines 1-4 and lines 8-11: **COMMENT** – This provision suggests there must first be a pilot or proof of concept study before implementing something to meet this great need. We believe there are successful programs elsewhere that can be used as models to create the incentives needed to make this feasible now.

Page 14, lines 21-22: **ACTION ITEM – Insert after “services” the following “a representative of a CMHC, a FQHC, an MHI, a hospital with an inpatient psychiatric unit, and other...”**. *Rationale* – See rationale for Page 12, line 35 above. As safety net providers these specific providers have the biggest stake in seeing that the outcome and performance measures are sound, doable, and aggressive enough to measurably raise the standard of care across the

state. These providers have been eager and valued participants in this redesign effort and we can expect that to continue if so recognized.

Page 15, line 4, Sec. 13, Regional service system-regulatory requirements **COMMENT**—This section includes a long list of regulatory oversight duties by several agencies. Just as work group efforts must be adequately funded, the public deserves to have these regulatory functions undertaken by dedicated staff with a high level commitment to the mission. There are many provisions in the redesign effort that add FTEs to the state government payroll. If the expectations by policy makers are that these are unrealistic assumptions then they should not support this redesign effort. It will take some upfront resources to make this work. See also Page 16, lines 8 and 9 as a case in point.

Page 17, line 21: **QUESTION** – Are any definitions or standards contemplated that must be met by a “regional administrator?

Page 17, line 27 et seq, Mental health and disability services regions—criteria: **COMMENT** – These concerns are more technical or are questions to enhance our understanding of the intent of some provisions.

- Page 17, lines 33-35: **QUESTION** – Does this subsection 2 give the director and the commission authority to waive any of the conditions included in subsection 3, (a)-(g)?
- Page 18, lines 7-13: **QUESTION** – If the answer to subsection 2 is negative, is subsection 3(c) the only criteria that can be waived? As the answer would seem obviously Yes, then there is no mechanism to waive, for example, the three county minimum. **COMMENT** – This would seem very problematic for Polk County, for example. Last year’s provisions for waiver were drafted and discussed but apparently have been abandoned.
- Page 18, line 12: **COMMENT** – The term “convincing evidence” is very problematic. To our understanding this is not a legally recognized standard of proof. There is a “clear and convincing evidence” standard which is well defined in case and statutory law but which would be a high standard indeed for the department director and the commission to overcome to grant a waiver. We recommend seeking a more artful term. Almost assuredly this authority will have to be exercised concerning the very rural parts of the state and the standard used to exercise that authority will likely be the subject of any resulting litigation.
- Page 18, lines 16-23: **COMMENT** – While this language is virtually identical to that in SF 525, it may need some clarification as the sentence structure could lead to different conclusions over which clauses modify which entity. For example, do any of the criteria following the words “federally qualified health center” apply solely to the FQHCs or do they likewise apply to the CMHCs?
- Page 18, line 31: **QUESTION** – The referenced “clear lines of accountability” relate to whom and how often?
- Page 18, lines 32-34: **COMMENT** – This requirement seems vague and the last phrase seems incomplete or at least confusing in its syntax.

- Page 19, lines 2-35 and Page 20, lines 1-26: **COMMENT** – As we noted in earlier commentaries, this implementation schedule seems overly aggressive and optimistic.
- Page 20, lines 7-8: **COMMENT** – This sub-section requires the regional transition plan designate a single targeted case manager to be funded by TXIX. This is very problematic for a number of Alliance members in areas currently using multiple TCMs. This issue will be addressed in greater detail in the context of the discussion over case management in general.

Page 20, line 27, Sec. 18, Regional governance structure: **COMMENT** – This section contains some of our greatest concerns about the workability of this regional structure.

- Page 21, line 1, **ACTION ITEM: Delete “or more”** – *Rationale* – Allowing more than one member from a county will likely create significant logistical and operational problems in many regions. Most regions are going to contain more than five counties and some could exceed ten. If a county board includes supervisors from both political parties there will be political pressure for both have at least one member on the regional board which means three people because the majority party will want to out vote the minority party to control the county’s one vote. Of course, that assumes each county gets just one vote on the regional board. The point is these boards will be unwieldy and the number of consumer members has yet to be determined.
- Page 21, lines 6-12, **COMMENT** – There is no provision designating who decides how many and who these consumer members are to be. It implies it is the supervisor members but that seems uncertain. This sub-section allows “at least” three consumers. Here again, there will be considerable pressure to have at least one per county and more than one type of consumer represented. Quorum issues, scheduling, and mileage expense are but a few of the concerns generated by sheer size of these governance boards. These boards could be larger than any other public policy deliberative body in the state except the Iowa House and Senate.
- Page 21, line 2-5, **ACTION ITEM – Delete the last sentence of this subsection.** *Rationale* – This is the most problematic provision in the entire bill draft. It says supervisors are the only governance board members who can vote on matters “involving the local public funding...” There is no practical way to implement this provision. How will the board decide if a decision involves county funds? What important decisions of vital concern to consumers would not be excluded? Does hiring an administrator fall into this category? Who will decide in the course of a meeting whether a “decision” is presented that limits who can vote on it? This provision will only breed distrust, cause protracted delays in decision making, and in some cases make the proceedings look like a circus run by people who fight all the time. This could hardly be an atmosphere for running a major public entity involving hundreds of thousands, if not millions, of dollars.
- Page 21, line 20: **COMMENT** – It seems incongruent for the administrator to unilaterally negotiate and execute these contracts apparently without the necessity for approval by the board that hires that entity.
- Page 21, line 35 and Page 22, line 1 **COMMENT** – This sentence seems to be drafted in error because it references the costs of the “regional administrator” and the intent must

be to limit the costs of regional administration. However, the substantive objection to this provision is the unrealistic and unquantified use of a 5% limit. This is the same figure included in SF 525 and we have noted the Alliance's objection to its continued unsubstantiated use ever since.

- Page 22, lines 4-6: **QUESTION** – What is the purpose or meaning of this section?

Page 25, lines 16-17: **COMMENT** – This period of 120 days to notify the department of a dispute is inordinately long and will likely result in providers waiting for months to be paid. We suggest drafters look at the system developed by health insurers and workers compensation insurers over issues about whether an injury is job related (and therefore payable by the work comp carrier) or not in which case it may be payable by the employer's health carrier. One of them pays the health care provider and the carriers settle up when the legal issue is resolved. In this case some mechanism should be worked out to deal with this so the parties and the providers don't have to wait until the legal dispute between the carriers is resolved. As for the issue of settlement in general, we remain unconvinced, but hopeful, that the provisions as now written will avoid merely substituting the issue of regional legal settlement for county legal settlement.

For further information or questions please contact:

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