

**THE IOWA ALLIANCE OF COMMUNITY MENTAL HEALTH CENTERS**  
**RECOMMENDATIONS TO THE IOWA GENERAL ASSEMBLY**  
**CONCERNING MENTAL HEALTH AND DISABILITY SERVICES SYSTEM REDESIGN**  
**HSB 646/SSB 3152**  
**February 17, 2012**

**ABOUT THIS COMMENTARY #4**

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Commentary #4 addresses HSB 646 and SSB 3125 (*hereafter cited simply as the Study Bill as they are identical in respects pertinent to this document*) and continues the format used in #3 by characterizing its critique as Action Items, Questions, and Comments. These are arranged in a consecutive page and line format to facilitate study rather than in order of importance. Many critique items are the same as those in #3 because the Study Bill is very similar to the January 26<sup>th</sup> draft. Commentary #5 will be issued in separate versions, one addressing the House file and one addressing the Senate file as these bills, and their respective amendments will likely begin to diverge in content.

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## 1. State Level Regulatory Oversight of Redesigned System

Throughout the Study Bill there are references to delegating to certain state governmental entities numerous regulatory and administrative oversight responsibilities. With important exceptions, these are most frequently the Department of Human Services (the department) or the Mental Health and Developmental Disabilities Commission (the commission). For example, the commission is asked to select functional assessment methodologies, approve county and regional management plans, and many others.

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This **ACTION ITEM** is to amend, where appropriate, by deleting "~~commission~~" and inserting "department."

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Page 7, lines 3 & 4; Page 8, lines 8 & 9; **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?

#### **10. Twelve-month Exclusionary Pre-Existing Period**

Page 7, lines 5-7: – This provision 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. **ACTION ITEM** – Delete this sentence or re-write the provision.

### **11. Mental Health Core Services**

Page 9, lines 1-29: **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? This is another argument for giving the director oversight and approval of regional budgets and allocations because they will be driven by the department’s determination of the costs associated with each of these core services.

### **12. Broaden the Terminology Describing Professionally Recognized Standards**

Page 10, lines 1 & 2: **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 caution against its use in this context as being too restrictive. Consideration should be given to “promising practices,” “emerging practices,” or “evidence informed practices,” or other broader professionally recognized standard(s).

### **13. Regional Financing Oversight**

Page 12, lines 4-35 and page 13, lines 1-7: 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) can we find language requiring approval of a region’s annual budget (fiscal plan) other than the regional governance board itself. This is either an unintended oversight or it is elsewhere in current law or the conforming amendments. For example, the Study Bill does not require that it be in the regional management plan that must be approved at the state level. We recommend language be inserted somewhere in this section affirmatively stating that the department must approve each region’s budget and its fiscal assumptions. [*Concerning the latter see the word “anticipated” on page 13, line 4.*]

### **14. Allowable Growth Factor Recommendations**

Page 12, lines 10-35: **COMMENT** – The Alliance believes working toward an Allowable Growth mechanism is worthy of careful consideration if it is intended to bring more predictability to regional budgeting. Regrettably, there seems to be little support in some important quarters for installing such a mechanism if the school aid formula mechanism currently being scrutinized is any predictor of a trend. If it gets serious consideration we are concerned that the membership of the commission has such a vested interest in the level of that growth factor that its recommendations will have little credibility and therefore would be largely a waste of valuable and expensive fiscal analysis resources. The Legislative Services Agency has great experience in doing this kind of analysis. If the governor prefers an executive branch agency, it may be prudent to have the Department of Management do it in the first place as it would have to do the analysis in the end for the governor anyway.

**15. Support for Mental health and disability services workforce development workgroup**

Page 13, line 17, Sec. 11, **COMMENT** – 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 urge that its staff support be adequately funded. This particular workgroup is proposed to have 23+ members with an agenda topic that ranks as one of the most chronically controversial in the public policy making arena. The tasks are extensive and require great technical expertise.

Moral and fiscal support from the most senior levels in the executive and legislative branches must be obvious to all the stakeholders. Timely success in this area is a good economic development strategy with an enormous impact on the well-being of our citizens. Failure in this critical area will stall the momentum 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.

**16. Inclusion of Regional Safety Net Providers on Workgroup**

Page 14, lines 13 & 14: Recognizing the value of the numerous public members on this workgroup, it is the health care providers that will be employing the individuals this work group seeks to find, train, and place throughout the state. These providers need to be well represented. The providers we recommend for specific mention are all specifically named in the Study Bill 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 invaluable. **ACTION ITEM** – Delete subparagraph (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.

**17. Outcomes and Performance Measures Committee—Specified Members**

Page 15, lines 25-35 and page 16, lines 1-16: As noted in item #15, 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. **ACTION ITEM** – Insert after “services” in line 35 the following “including a representative of a CMHC, a FQHC, an MHI, a hospital with an inpatient psychiatric unit, and other...”

**18. Mental health and disability services regions—criteria**

Page 19, line 5 et seq.; **COMMENT** – These concerns are more technical or are questions to enhance our understanding of the intent of some provisions.

- a) Page 19, lines 11-13: **QUESTION** – Does this subsection 2 give the director and the commission authority to waive any of the conditions included in subsection 3, (a)-(g)? Again, we question the wisdom of allowing the commission discretion in approving or disapproving regional composition given its compositional bias.

- b) Page 19, lines 20-26: **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 legislative provisions for waiver were drafted and discussed but apparently have been abandoned.
- c) Page 19, line 25: **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.
- d) Page 19, lines 29-35 and page 20, line 1: **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?
- e) Page 20, line 9: **QUESTION** – The referenced “clear lines of accountability” relate to whom and how often?
- f) Page 20, lines 10-12: **COMMENT** – This requirement seems vague and the last phrase seems incomplete or at least confusing in its syntax.
- g) Page 20, lines 15-35 and Page 21, line 1: **COMMENT** – As we noted in earlier commentaries, this implementation schedule seems overly aggressive and optimistic.
- h) Page 21, lines 20-21: **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.

### 19. Regional governance structure

Page 22, line 5, Sec. 18: **COMMENT** – This section contains some of our greatest concerns about the workability of this regional structure.

- a) Page 22, line 14, 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. **ACTION ITEM:** Delete “~~or more~~”

- b) Page 22, lines 19-25, **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.
- c) Page 22, lines 15-18: 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. **ACTION ITEM** – Delete the last sentence of this subsection.
- d) Page 22, lines 33-35: **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.
- e) Page 23, line 13-16: **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, recent committee testimony notwithstanding.
- f) Page 23, lines 17-19: **QUESTION** – What is the purpose or meaning of this section?

## **20. Notification of Residency Dispute**

Page 26, lines 34-35 and page 27, line 1: **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. 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 disputants is resolved. As for the issue of settlement in general, we remain 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 expressions of interest in this document please contact Cindy Kaestner or Patrick Schmidt, Alliance co-chairs, or any member of the Alliance's advocacy team:

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Page 7, lines 3 & 4; Page 8, lines 8 & 9; **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?

#### **10. Twelve-month Exclusionary Pre-Existing Period**

Page 7, lines 5-7: – This provision 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. **ACTION ITEM** – Delete this sentence or re-write the provision.

### **11. Mental Health Core Services**

Page 9, lines 1-29: **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? This is another argument for giving the director oversight and approval of regional budgets and allocations because they will be driven by the department’s determination of the costs associated with each of these core services.

### **12. Broaden the Terminology Describing Professionally Recognized Standards**

Page 10, lines 1 & 2: **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 caution against its use in this context as being too restrictive. Consideration should be given to “promising practices,” “emerging practices,” or “evidence informed practices,” or other broader professionally recognized standard(s).

### **13. Regional Financing Oversight**

Page 12, lines 4-35 and page 13, lines 1-7: 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) can we find language requiring approval of a region’s annual budget (fiscal plan) other than the regional governance board itself. This is either an unintended oversight or it is elsewhere in current law or the conforming amendments. For example, the Study Bill does not require that it be in the regional management plan that must be approved at the state level. We recommend language be inserted somewhere in this section affirmatively stating that the department must approve each region’s budget and its fiscal assumptions. [*Concerning the latter see the word “anticipated” on page 13, line 4.*]

### **14. Allowable Growth Factor Recommendations**

Page 12, lines 10-35: **COMMENT** – The Alliance believes working toward an Allowable Growth mechanism is worthy of careful consideration if it is intended to bring more predictability to regional budgeting. Regrettably, there seems to be little support in some important quarters for installing such a mechanism if the school aid formula mechanism currently being scrutinized is any predictor of a trend. If it gets serious consideration we are concerned that the membership of the commission has such a vested interest in the level of that growth factor that its recommendations will have little credibility and therefore would be largely a waste of valuable and expensive fiscal analysis resources. The Legislative Services Agency has great experience in doing this kind of analysis. If the governor prefers an executive branch agency, it may be prudent to have the Department of Management do it in the first place as it would have to do the analysis in the end for the governor anyway.

### **15. Support for Mental health and disability services workforce development workgroup**

Page 13, line 17, Sec. 11, **COMMENT** – 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 urge that its staff support be adequately funded. This particular workgroup is proposed to have 23+ members with an agenda topic that ranks as one of the most chronically controversial in the public policy making arena. The tasks are extensive and require great technical expertise.

Moral and fiscal support from the most senior levels in the executive and legislative branches must be obvious to all the stakeholders. Timely success in this area is a good economic development strategy with an enormous impact on the well-being of our citizens. Failure in this critical area will stall the momentum 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.

### **16. Inclusion of Regional Safety Net Providers on Workgroup**

Page 14, lines 13 & 14: Recognizing the value of the numerous public members on this workgroup, it is the health care providers that will be employing the individuals this work group seeks to find, train, and place throughout the state. These providers need to be well represented. The providers we recommend for specific mention are all specifically named in the Study Bill 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 invaluable. **ACTION ITEM** – Delete subparagraph (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.

### **17. Outcomes and Performance Measures Committee—Specified Members**

Page 15, lines 25-35 and page 16, lines 1-16: As noted in item #15, 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. **ACTION ITEM** – Insert after “services” in line 35 the following “including a representative of a CMHC, a FQHC, an MHI, a hospital with an inpatient psychiatric unit, and other...”

### **18. Mental health and disability services regions—criteria**

Page 19, line 5 et seq.; **COMMENT** – These concerns are more technical or are questions to enhance our understanding of the intent of some provisions.

- a) Page 19, lines 11-13: **QUESTION** – Does this subsection 2 give the director and the commission authority to waive any of the conditions included in subsection 3, (a)-(g)? Again, we question the wisdom of allowing the commission discretion in approving or disapproving regional composition given its compositional bias.

- b) Page 19, lines 20-26: **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 legislative provisions for waiver were drafted and discussed but apparently have been abandoned.
- c) Page 19, line 25: **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.
- d) Page 19, lines 29-35 and page 20, line 1: **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?
- e) Page 20, line 9: **QUESTION** – The referenced “clear lines of accountability” relate to whom and how often?
- f) Page 20, lines 10-12: **COMMENT** – This requirement seems vague and the last phrase seems incomplete or at least confusing in its syntax.
- g) Page 20, lines 15-35 and Page 21, line 1: **COMMENT** – As we noted in earlier commentaries, this implementation schedule seems overly aggressive and optimistic.
- h) Page 21, lines 20-21: **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.

### 19. Regional governance structure

Page 22, line 5, Sec. 18: **COMMENT** – This section contains some of our greatest concerns about the workability of this regional structure.

- a) Page 22, line 14, 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. **ACTION ITEM:** Delete “~~or more~~”

- b) Page 22, lines 19-25, **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.
- c) Page 22, lines 15-18: 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. **ACTION ITEM** – Delete the last sentence of this subsection.
- d) Page 22, lines 33-35: **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.
- e) Page 23, line 13-16: **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, recent committee testimony notwithstanding.
- f) Page 23, lines 17-19: **QUESTION** – What is the purpose or meaning of this section?

## **20. Notification of Residency Dispute**

Page 26, lines 34-35 and page 27, line 1: **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. 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 disputants is resolved. As for the issue of settlement in general, we remain 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 expressions of interest in this document please contact Cindy Kaestner or Patrick Schmidt, Alliance co-chairs, or any member of the Alliance's advocacy team:

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