MHDD SYSTEM REDESIGN REPORT

TO GOVERNOR THOMAS J. VILSACK
AND THE 80th IOWA GENERAL ASSEMBLY

Prepared by the

Iowa Mental Health and Developmental Disabilities Commission

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Julie Jetter, Central Point of Coordination (CPC), Buchanan County Community Services Director, Independence
Brian Ridler, AFSCME Nominee, Resident Treatment Worker at Woodward State Resource Center, Woodward
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Lori Reynolds, Parent of an Individual with a Disability, Executive Director of Iowa Federation of Families for Children's Mental Health, Anamosa
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Member of House Human Resources Committee
Representative Mark Smith, Marshalltown (Marshall)
Licensed Independent Social Worker; Ranking Member on House Human Resources Committee; Health and Human Services Appropriations Subcommittee

EXECUTIVE SUMMARY

The Mental Health and Developmental Disabilities (MHDD) Commission recommends that several aspects of the current system for delivering adult disability services be changed to provide better access to services, to fund core services to more people statewide, to equalize county funding obligations, and to distribute funds on a more equitable basis.

The recommendations will assure universal access to information and outreach, to initial service coordination, and to crisis services. The system will link individuals with disabilities to basic supports such as housing subsidies, utility subsidies, food assistance, transportation subsidies, medical and dental care. Funds will be available where each individual resides and will not be determined on an archaic calculation of "legal settlement." While this does not assure that each core service will be available in every locality, it does assure equal access to services. Adults with mental illness, chronic mental illness, mental retardation, developmental disabilities other than mental retardation, or disability due to brain injury will be eligible if they meet standardized functional assessment criteria and either qualify for Medicaid funding or have an income below 150% of the federal poverty level.

The redesigned system will provide funding for core services including coordination and monitoring services, community services and supports, inpatient services, and residential services. See page 10 "Core Services" for more information about core services.

Funds for the adult disability system will come from county property taxes, state appropriations, federal funds, and other sources. Counties will contribute at an equalized property tax rate threshold. State and federal funds will be distributed to counties or coalitions of counties using case rates based on functional assessments of eligible individuals. This assures that individuals will have access to available funding based on their individual needs.

The Commission anticipates that system changes will occur over the course of the next six to eight years. Section L details the phase-in strategy. In Phase 1, the Legislature would authorize the changes and the system would develop fiscal data and tools. In Phase 2, the equalized property tax rate and the new method for distributing MH/DD funds would be implemented. In Phase 3, all affected populations would be assured funding for core services statewide. Finally, in Phase 4, each county or consortium of counties (in this report called "management entity") would relinquish funding obligations for individuals that have "legal settlement" in the county. Instead, they would fund individuals who reside in the management entity. Appendix D provides more details.

It is likely that the new system will require additional revenue. First, a $200,000 appropriation is needed to fund collection of fiscal data, development of functional assessment tools, and development of case rates. Revenue to fund statewide delivery of core services may come from additional appropriations, proposed property tax restructuring, or other sources. See Appendix C for an explanation of costs of redesigning the system.

State legislation passed in 2002 expanding the duties of the MHDD Commission, and House File 529, found in Appendix B, provided impetus for the redesign effort and this report. The

Olmstead Decision (*Olmstead V. L. C. [98-536] 527 U.S. 581*) handed down by the US Supreme Court provided additional impetus. This report does not make recommendations regarding redesign of an MHDD system for children. The MHDD Commission intends to make recommendations regarding the children's MHDD system in a report to the legislature in December 2004.

The report is a product of the MHDD Commission and the work of 150 Iowans that voluntarily served on workgroups meeting regularly for more than a year. The volunteers included individuals with disabilities and their families, representatives of county and state government, advocates, educators, and service providers. A copy of the full report and its appendices can by obtained from DHS staff at 515-281-4593, bflores1@dhs.state.ia.us, or on the Iowa Department of Human Services website at http://www.dhs.state.ia.us/publication.asp.

INTRODUCTION

This report sets out recommendations from the Iowa Mental Health and Developmental Disabilities Commission (MHDD Commission) for redesigning Iowa's system of support for adults with mental health needs, developmental disabilities, or brain injuries. In this report, this system will be identified as the MHDDBI system. See definitions for key terms in Appendix A.

The Commission also has a statutory duty to set out similar system redesign recommendations for children. The Commission anticipates collecting and analyzing information about the children's MHDDBI system in 2004, and issuing recommendations for system improvement in December 2004.

The Commission had several reasons to study and recommend changes in the adult MHDDBI system this year. On February 1, 2001, President George W. Bush announced the New Freedom Initiative. Founded upon the spirit of the Americans with Disabilities Act and the Olmstead Supreme Court decision, the New Freedom Initiative represents a comprehensive set of proposals designed to ensure that Americans with disabilities have the opportunity to learn and develop skills, engage in productive work, make choices about their daily lives, and participate fully in their communities.

Nationally there is considerable momentum in the mental health community to focus services, supports, and funding on individuals needs. The President's New Freedom Commission, spearheaded by President George W. Bush, focuses attention on the centrality of person-centered planning and a recovery-oriented approach, the importance of evidence-based practices, the need to expand service access to rural and otherwise underserved areas, and the necessity of having a comprehensive state-wide mental health plan.

Iowa Governor Tom Vilsack issued Executive Order 27 in February 2003 to call on state agencies to "move purposefully to swiftly implement the Olmstead Decision." The order directed the heads of 20 state agencies to undertake steps to identify and address barriers to community living for individuals with disabilities and long term illnesses in Iowa.

In Iowa we are taking a second look at how best to serve individuals that have high intensity needs or combinations of needs. Some of these individuals currently live in state Resource Centers, state Mental Health Institutions, or Intermediate Care Facilities for Persons with Mental Illness or Mental Retardation but would prefer to be in their own homes or communities. The Olmstead/Real Choices Consumer Task Force and others are seeking ways to provide opportunities for those individuals to live, learn, work, recreate and otherwise contribute in their chosen communities. The Commission is partnering with the task force, the Governor's Developmental Disabilities Council, and others to assure that our system best serves the needs of these individuals.

In 2002, legislation combined the MHDD Commission with the State County Management Committee and reshaped the Commission's membership. Consistent with its new legislative mandate, the reconstituted MHDD Commission began to redesign the mental health,

developmental disability, and brain injury service delivery system in November 2002. In spring of 2003, House File 529 (Appendix B) required that by December 31, 2003, the Commission recommend changes that would improve the system. It asked that the Commission include in those recommendations:

- Assurance that individuals with mental illness, mental retardation, developmental disabilities, or brain injury have access to services, regardless of where they live
- Assurance that individuals have access to available funding, based on their individual needs
- Statewide standards for clinical and financial eligibility
- A minimum set of core services that will be funded for eligible individuals based on their individual unmet needs
- A new funding process that equalizes distribution of MHDD funds

The legislation did NOT require that the system attempt to operate using reduced appropriations. Neither did it limit the Commission redesign efforts to "budget neutral" recommendations.

Each year more than 50,000 of Iowa's adults use one or more services funded by the disability services system. The services range from short-term outpatient counseling provided to an individual with depression by a community mental health center, to intensive mental health treatments and extended institutional stays for individuals with severe mental health needs and challenging behaviors. Families may need nursing or respite care to supplement the primary care they provide for an individual with autism or brain-injury. An individual with profound mental retardation may need care in a supervised environment 24 hours a day. The special needs of individuals with disabilities range from no special needs whatsoever to needs for financial management training, medication management, assistive devices, transportation, personal care attendants, assertive community treatment or trained peer support. In other words, the needs are as individual as the individuals themselves.

Although some families can pay for the full range of services and supports their loved one needs, many cannot. Iowa allocates county tax revenue, makes state legislative appropriations, and directs federal health system dollars (primarily Medicaid) toward meeting the needs of those who cannot pay the full cost themselves.

Iowa funds and delivers services through local management by county Central Points of Coordination (CPCs), services from a network of providers, administrative oversight by the Iowa Department of Human Services, and policy oversight by the Mental Health and Developmental Disabilities (MHDD) Commission. The web site for the MHDD Commission is www.dhs.state.ia.us/MHDD.

The MHDD Commission formed workgroups composed of individuals with disabilities, their family members, advocates, service providers, county personnel, and various state agency personnel. To date, over 150 people have served on one or more workgroups. The redesign initiative has the support and interest of the legislature, Lt. Governor Sally J. Pedersen, DHS Director Kevin Concannon, and the Iowa State Association of Counties. In March 2003, the MHDD Commission established a vision, values, principles, and foundations for the redesigned system (see Vision, System Values, System Principles, and System Foundation sections of the

report). The workgroups have proposed, and the Commission adopted, a redesign strategy based on self-directed and person-centered planning and service coordination. Through this report, the Commission is sharing its recommendations for system change.

VISION FOR THE REDESIGNED SYSTEM

The VISION AND MISSION OF THE MHDD COMMISSION is to build and implement a coordinated system for Iowans with mental illness, mental retardation or other developmental disabilities, or brain injury, where individuals receive necessary, high quality services and supports on an equitable, timely and convenient basis, enabling them to live, learn, work, recreate and otherwise contribute in their chosen communities.

SYSTEM VALUES

Choice: The ability of Iowans with disabilities and their families to make informed choices about the amounts and types of service and supports received.

Empowerment: The reinforcement of the fundamental rights, dignity and ability of Iowans with disabilities to provide valuable input, accept responsibility, make informed choices, and take risks.

Community: The system supports the right, dignity, and ability of all individuals with disabilities to live, learn, work, and recreate in the communities of their choice.

SYSTEM PRINCIPLES

1. Individuals with disabilities have the same fundamental rights as non-disabled persons.

2. Unique individual and family strengths, needs, choices and preferences are the basis for services and support planning and delivery.

3. Individuals and their families take the lead in identifying service and support needs and in planning to meet those needs. Service and support planning and delivery encourage the development and enhancement of natural support systems of individuals and their families. Individuals and their families have the right to appeal if the planning, access or delivery of services and supports does not meet their needs and choices.

4. Quality services are provided in a manner that encourages and supports the development of each individual's abilities and minimizes intrusion in or disruption of the individual's life style.

5. Housing should be affordable, safe, stable, and in settings that maximize community integration and opportunities for community inclusion.

6. Funding for service and support provision follows the individual needs and choices of individuals and their families. Services and supports are provided in a culturally competent manner, focus on outcomes and the prevention of the need for more costly services and supports.

7. Individuals and their families actively participate in service and support system planning, resource prioritization, program implementation, and evaluation of the quality and effectiveness of services and supports.

8. Services are delivered by a means that is accountable for administering a system of services in a consistent, fair, equitable, high quality, and efficient manner. There should be a single point of financial, clinical and administrative accountability.

9. There will be a comprehensive, effectively working plan for Iowa communities to ensure that individuals with disabilities receive services in the most integrated setting appropriate to their needs. This plan would implement the Olmstead Supreme Court decision which states that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act.

10. Services and supports may be provided by public, private, non-government, and/or faith-based organizations and entities with established roles in the system of services and supports.

SYSTEM FOUNDATION

The System foundation is based on the following fundamental philosophies:

1. The system begins with each individual who needs information, assessment, or services.
2. A plan of supports is developed based on the needs of the person.
3. Supports are developed based on the plan, which is based on the person.
4. Outcome-based quality assurance standards for service/support providers are used to allow the development of the supports needed, which are based on the plan, which is based on the person.
5. Outcome-based standards are based on outcomes in the person's life.
6. Most people who wish to live in the community can do so given the appropriate supports.
7. Person-centered planning and individual budgeting are tools that support self- direction.
8. The plan belongs to the person, not to service providers. It crosses systems and funding streams.
9. Services do not come in packages.
10. Core services are accessible across the state.
11. Services are identified flexibly to allow creativity and development of new services and new service providers.
12. Training is ongoing for all system participants including consumers, support staff, funders, and the public.
13. The system assures a level of health and safety while balancing rights of choice.
14. Individual/Family responsibilities should be included and encouraged.
15. Individuals should have access to life long learning opportunities.

16. People have the potential for recovery and growth
17. Individuals should not be forced into or to stay in poverty to receive supports.
18. Individuals with mental illness, mental retardation, developmental disabilities, or disabilities due to brain injury will have substantial representation on all policy-making bodies in the system.
19. The system must be adequately funded to meet the needs of the individuals who use it.

RECOMMENDATIONS

A. ASSURE UNIVERSAL ACCESS TO INFORMATION, SERVICE COORDINATION AND CRISIS/EMERGENCY SERVICES

The Commission recommends providing information to those who are seeking disability service information and outreach to those who may be unaware of but are in need of disability services.

1. If eligible, the individual must apply for federally funded services and supports.
2. Individuals should be linked to emergency services without regard to individuals' residency or financial eligibility.
3. Service coordination and crisis/ emergency services should be reasonably available locally.

B. ESTABLISH FINANCIAL ELIGIBILITY STANDARDS

The Commission recommends the following minimum financial eligibility, resource limits, and co-pay standards for people accessing disability services funding:

1. People who have income below 150% of the federal poverty level (FPL) should have services 100% publicly funded.
2. People with incomes above 150% FPL may be required to pay a co-pay based on a statewide maximum sliding scale.
3. Because utilizing available federal funding is a high priority, individuals may be denied eligibility for county funded services and supports if they choose not to apply for federally funded services and supports.
4. Resource limits should be established that are consistent with Social Security resource limits. For persons who do not, or likely will not qualify for federal disability programs, but who otherwise meet the income and functional guidelines for service, the following accounts should be exempt from resource limits:
   a. Retirement accounts that are in the accumulation stage
   b. Burial accounts
   c. Medical savings accounts
   d. Assistive technology accounts

C. ESTABLISH FUNCTIONAL/DIAGNOSTIC ELIGIBILITY STANDARDS

The Commission recommends using the following diagnostic criteria:

1. The person is diagnosed with mental illness OR
2. The person is diagnosed with chronic mental illness OR
3. The person is diagnosed with mentally retardation OR
4. The person is diagnosed with a development disability OR
5. The person has a brain injury as defined in Iowa Administrative Code 441-83.81 AND
6. The person achieves a qualifying functional assessment score.

The Commission recommends adopting, with consumer input, statewide standardized functional assessment tools to be used to establish both system funding eligibility and the level of services and supports that an individual needs. It may be that separate assessment tools and separate processes are the best way to accomplish both these goals.

Iowa Code §229.1 defines "mental illness" and "seriously mentally impaired" for the purpose of involuntary civil commitments. The Commission supports maintaining those definitions for that purpose. However, the Commission supports discontinuing use of "chronic mental illness" as defined in Iowa Administrative Code 441-90.1 as a disability category, and beginning to use "serious mental illness" as defined in Section 1912(c) of the Public Health Services Act as the disability category instead.

D. RESIDENCY

The Commission recommends:
1. Establishing a definition of residency. A proposed definition is listed in the definitions in appendix A. Some individuals who are present in Iowa and otherwise eligible for MHDDBI funding may not be a resident of any management entity pursuant to this definition. Funding for those individuals will be available through the state entity. See definition of "eligible non-resident".
2. Establishing a statewide standard for "proof of residency" that presumes an individual lives where they say they live, with minimal documentation required. We suggest the following could be used to document residency: driver's license, motor vehicle registration, mailing address, telephone bill, rent receipt, lease agreement, property tax bill, utility bill, wage stub, tax return, employment or wage records or receipts, bank account statements, or documents from the person or shelter with whom the homeless individual is staying. Residency could be also be determined by consulting a telephone or city directory, interviewing the applicant at home, or interviewing a knowledgeable third party.
3. Establishing a statewide data system that identifies the residency of each individual eligible for MHDDBI funds.
4. Establishing a mechanism for individuals to contest a residency determination. It is important for the mechanism to use a disinterested decision maker and allow quick resolution of most disputes.

EXCEPTIONS TO FUNDING FOR RESIDENTS

Residency is important in the redesigned system because MHDDBI funds will be distributed to management entities based on the number of residents that are eligible for MHDDBI funds.

However, not all individuals who are residents of a management entity will be eligible to receive MHDDBI funds through that management entity.

Individuals placed in or committed to a state mental health institution, state resource center, or a licensed residential facility; or receiving residential supports through a home and community based services (HCBS) waiver; or persons in the custody of the department of corrections, will not be considered residents of the management entity where they are receiving the services. Under the definition of residency found in appendix A, they will be considered absent from their home management entity during their stay in an institution or facility or receiving HCBS waiver residential services, and they will continue to receive funding through their home management entity. However, if the person meets all criteria for receiving MHDDBI funds and is placed in or committed to the institution, but is not a resident of any management entity, the state entity will provide the funding for this "eligible non-resident".

E. **CORE SERVICES**

The Commission has identified a need for a minimum set of core services that are available to all eligible individuals no matter where they live. While this does not assure that each core service will be available in every locality, it does assure that the core services will be publicly funded by the MHDDBI funds managed by each management entity.

The Commission recommends:

1. Maintaining the current level of services as the system moves toward requiring that core services be funded statewide. Individuals already receiving services will continue to receive services, regardless of disability. The Commission recognizes that during this transition period, management entities must be allowed to make management decisions that allow them to stay within available funds.
2. Requiring, by the end of the phase-in period, the following minimum services that should be publicly funded for eligible individuals:
   a. Coordination and monitoring services
   b. Community Services and Supports:
      - Outpatient mental health treatment services
      - Outpatient mental health crisis planning and intervention services
      - Rehabilitative services
      - Habilitative services
      - Support services, i.e. supported community living services, community support services, peer support services
      - Respite services
      - Vocational services
      - Educational services
      - Personal growth services
      - Recovery-oriented services
   c. Inpatient Services
      - Inpatient mental health treatment services

- Sub-acute services

d. Residential Services
   - Intermediate care facility services for individuals with mental retardation (ICF/MR)
   - Intermediate care facility services for individuals with mental illnesses (ICF/PMI)
   - Residential care facility services

e. Other cost effective services, treatments and supports most likely to help an individual achieve their outcomes as identified by the individual's plan and authorized by the management entity.

F. INDIVIDUALS SERVED BY THE SYSTEM

The Commission recommends that individuals who access the system and its services should, to the degree possible:

1. Participate in developing, implementing and monitoring their individual service plan.
2. Participate or lead in defining their own needs, service responses and outcomes.
3. Choose and implement methods to achieve their desired outcomes.
4. Accept personal responsibility to achieve the goals they have established within their service plan.
5. Lead or participate in selecting their service coordination team.
6. Advocate for oneself.
7. Participate in the funding of their services.

G. SERVICE COORDINATION

The Commission recommends the following service coordination roles and responsibilities:
1. Establish a person's eligibility for publicly funded services.
2. Work with the individual to develop and implement a plan for services and supports that meets the individual's needs based on person-centered planning principles.
3. Work with the individual to advocate for services, funds, and supports that meet their needs.
4. Encourage the individual in the development of skills in self-direction and planning.
5. Compile data that indicates whether outcomes are met, and confer with the individual to adjust the plan if desired outcomes are not met.
6. Facilitate service coordination team meetings, if needed.
7. Coordinate, broker, manage and monitor services and supports established in the service coordination plan in a seamless, integrated system of care.
8. Educate the individual served and others as appropriate about the disability system.

The Commission recommends service coordination with the following characteristics:
1. Service coordination allows access to services without a case manager if it is appropriate to do so.
2. Service coordination is available to any individual who might benefit, regardless of funding source.

3. Service coordination is flexible enough to be provided intermittently based on the individual's need.
4. The need for service coordination is based on functional assessment, not the number of services provided or Medicaid eligibility.
5. Service coordination may be provided by a natural support or by the individual with a disability.
6. Service coordination may include functions such as mentoring to assist a person with self-directed care, fiscal intermediaries, or benefit planners.
7. Service coordination is a function, not a service. It may be provided as a stand-alone resource or integrated into a support team.

H. **MANAGEMENT ENTITIES**

The Commission recommends that the physical boundaries of management entities shall be a single county or a consortium of counties organized by mutual agreement as allowed by the Code of Iowa Chapter 28E.

The Commission recommends the following functions of the management entities:

FISCAL

1. Responsible to determine and manage eligibility for MHDDBI funding.
2. Budget for planned expenditures of MHDDBI funds.
3. Contract with providers of services, and set rates of reimbursement.
4. Pay for services provided to individuals meeting eligibility guidelines for publicly –funded services.

OPERATIONAL

5. Develop operational policies and procedures for the management entity.
6. Develop performance-based contracts with providers that require a person-centered planning process.
7. Monitor provider compliance with contracts.
8. Oversee the implementation and utilization of an outcome-based system in which financial incentives will be based on achievement of outcomes.
9. Conduct quality assurance activities as required.
10. Develop and implement utilization management guidelines.
11. Provide a statement to each individual showing the cost of that individual's services.
12. Develop management entity policies and procedures, strategic plans, and annual reports according to state standards and submit them for approval by the Department of Human Services and MHDD Commission.

COORDINATION

13. Develop community capacity to provide services for high need individuals.

14. Participate in and maintain the management entity's portion of the statewide information system.
15. Collaborate with people with disabilities, family members, advocacy groups, and other stakeholders and with local entities that impact the disabilities system.
16. Actively solicit and incorporate input from individuals with disabilities, family members, other management entities, service coordination entities, service providers, and the state.

I. STATE ENTITY

The MHDD Commission recommends the following role clarifications within the state entity:

1. The MHDD Commission should be renamed the MHDDBI Commission, to better reflect its responsibilities in serving individuals with mental health needs, developmental disabilities, and brain injuries.
2. The MHDD Commission should be the primary policy-making authority for the MHDDBI system.
3. A division or divisions should be established within the Department of Human Services that comprise the state's mental health authority, developmental disability authority, and the brain injury authority.

The Commission recommends the following functions of the state entity:

FISCAL

1. Maximize federal, state and other dollars.
2. Consolidate disability funding to the extent possible and allocate dollars to the management entities.

OPERATIONAL

3. Develop a single statewide plan delivering services and supports to individuals with mental illness, developmental disabilities, and brain injury.
4. Recommend standards for the policies and procedures, strategic plans, and annual reports that each management entity must develop.
5. Monitor and approve the policies and procedures, strategic plans, and annual reports that the management entities submit to the Department of Human Services and MHDD Commission.
6. Recommend financial, clinical, and functional standards that individuals must meet to be eligible for disability-funded services.
7. Recommend statewide eligibility determination process incorporating an ongoing functional assessment.
8. Apply for and administer grants.
9. Recommend quality assurance standards including standards for credentials, accreditation, auditing, training, technical assistance and licensing.

10. Oversee the implementation and utilization of an outcome-based system in which financial incentives will be based on achievement of desired outcomes.
11. Conduct research and evaluation of the Iowa system including the review of Iowa's best practices and those of other state programs to identify best practices.
12. Recommend uniform standards for which service coordination functions must be publicly funded.
13. Develop and recommend standards for service coordination delivery options, which include integrated, independent, and self-directed service coordination.
14. Require each management entity to assure that minimum standard service coordination options are reasonably available locally.
15. Develop an automated, technology-based financial eligibility process that is interactive with Medicaid financial eligibility process.

COORDINATION

16. Create, share and maintain an information technology system.
17. Create and maintain an interface between and among DHS divisions, other state departments and other entities affecting disability issues.
18. Actively solicit and incorporate input from the individuals served, service coordination entities and management entities.
19. Provide information to the public about Iowa's disability system.

J. STATE RESOURCE CENTERS AND MENTAL HEALTH INSTITUTIONS

No area has experienced more change in recent years than the area of institutional services for people with disabilities. We have learned that some people, regardless of disability, do best when they live in non-institutional, community settings. It is incumbent upon our system to direct vision, effort, and money toward developing community capacity so that those who can "live, learn, work, recreate and otherwise contribute in their chosen communities" are supported in doing so.

Our system must also continue to provide some types of care and treatment in an institutional setting. The state of Iowa does not have the community capacity to meet the needs of all eligible individuals. Our institutional settings will continue to provide service options for individuals with high medical or behavioral needs. In addition they will continue to provide safety for both individuals being served and others living in the community.

In this section, the Commission recommends that the system develop and implement a strategy that clarifies how the system will use state-operated mental health institutions and state resource centers, how to help build community capacity to provide non-institutional places to live, and how to align institutional funding strategy with the system funding strategy.

The Commission recommends that the system develop and implement a strategy for use of state-operated mental health institutions (MHI) and state resource centers (RC), including the following:

1. Require the state entity and its stakeholders to develop an implementation strategy that implements Olmstead and provides a seamless transition to operation of the state MHIs and RCs as specialized “niche” providers of services subject to consumer choice and emerging residential best practice trends.
2. Recommend a definition of the mission of the MHIs that reduces residential treatment and focuses on acute treatment.
3. Recommends a definition of the mission of the RCs to ensure that they are focused on serving persons who cannot be served in the community.
4. Monitor MHI and RC lengths of stay, budgets, staffing, bed capacity, costs per admission, and geographic areas served and require corrective action to better use resources.
5. Provide onsite short-term stays for evaluations or acute care stabilization.
6. Provide long-term care if the system fails to develop community capacity to provide such care.
7. Work with Department of Public Health substance abuse division to integrate access, treatments, programs, and funding for individuals with dual diagnoses.
8. Develop specialized forensic capacity to address the potential for violent situations that includes expertise, consistent protocols, and housing arrangements as appropriate.
9. Convert campus buildings for use of alternate programs operated by government and non-government providers.

STRATEGY FOR BUILDING COMMUNITY CAPACITY

The Commission recommends that the system develop and implement a strategy for building community capacity to provide housing, treatment, and supports outside the state institutions as follows:

10. Work with management entities to develop community capacity to serve individuals consistent with the Olmstead Supreme Court Decision.
11. Build community capacity by providing training and technical assistance in ‘Best Practices’ to providers, family members and other members of a person’s support team.
12. Build community capacity by providing case consultation; 24-hour emergency assistance and referral; on-site evaluations (within the person’s home environment if the individual is willing); off-site evaluations (within a more controlled environment); teaching centers for professionals and para-professionals; training consumers to build capacity for independent living.

STRATEGY FOR ALIGNING INSTITUTIONAL FUNDING

The Commission recommends the following:

13. Work towards being more entrepreneurial and competitive through such mechanisms as partnering with the private sector for collaborative programs; eliminating the Medicaid IMD (Institution for Mental Disease) exclusion (applies only to MHIs); using net budgeting; or using other mechanisms to generate additional operating revenues.
14. Abide by the same licensure requirements and per diem calculations and limitations as community providers.

15. Isolate institutional net salary appropriations and make them part of state institutions allowed costs so that a true per diem cost can be calculated.
16. Eliminate the county per diem calculation, and instead use only the Medicaid allowed cost calculation (currently allowed costs for Medicaid per diem calculation are different than the allowed costs for county per diem calculation).
17. Remove the percentage caps on the per diems counties currently pay (counties currently pay only a percentage of the total amount it costs to provide services to a county funded individual). This should be done only if all the money is added to the state and federal MHDDBI fund, and only if the state institutions are subject to the same standards as other providers.
18. Assure that some expenses of the institutions are not included as allowable costs in calculating the per diem (such as special highway construction cost or capital outlay) and should not be made available to the MIDDBI fund.
19. Clarify the projected number of people at the state institutions that are "eligible non-residents" so that funding for those people can be retained by the state entity to fund their services.
20. Clarify that management entities will have full responsibility for funding the stays of all their residents at MHIs and RCs, with the following exceptions:
    - Persons who have third party coverage
    - Persons who do not meet the eligibility guidelines of the management unit, including clinical necessity guidelines
    - Individuals at the MHIs under Iowa Code Chapter 812 "Confinement of Dangerous Persons and Persons with Mental Incompetence
    - Children
    - People committed to the institution pursuant to Iowa Coder 229A

K. DISABILITY SERVICES FUNDING

The current methods of funding the county- managed portion of the disability system are unfair and inequitable. State dollars are not distributed based on need. Each citizen of Iowa is not contributing an equal nor proportional share. The dollar amount raised is capped so as local valuations change the contribution per person changes inversely to their ability to pay (counties with lower valuations pay more per thousand while counties with higher valuations pay less). In fiscal year 2004, the amount of tax ranges from a low of 35 cents per thousand to a high of $3.13 per thousand.

The Commission proposes to establish a levy range with a minimum and maximum rate to address the inequalities in the property taxes. The minimum of the range will assure that each dollar of taxable valuation will generate an equal levy amount to support the newly designed system, including all the core services with standard eligibility guidelines. Having a maximum eligibility rate allows those counties that want to provide more than core services to raise the money to do this.

The Commission is also proposing a case rate allocation methodology that allocates non-property tax money to each management entity based on the cost associated with that cluster of clients and

the management entity's financial responsibility for those clients, less what the entity is able to raise through the minimum levy.

ASSUMPTIONS

The Commission makes these assumptions about system funding:

1. The state, the federal government through the Medicaid program, and the management entities should each bear financial risk for this funding system.
2. Local property tax is a stable source of revenue when compared to state income or sales tax.
3. Individuals are best served when funding comes from a balanced use of federal, state, and county dollars.
4. Counties where the tax base is increasing need to be able to capture and use that growth for the benefit of the MHDDBI populations they serve.
5. It is prudent to leverage more federal dollars through increased Medicaid eligibility strategies and program coverage, while maintaining a balance of funding from federal, state and county sources.
6. Other support systems already in place that serve the MIDDBI populations will continue to be funded and utilized as part of a complete set of services and supports.
7. Data collected and analyzed by the system over the next two years will reveal how much additional revenue the MHDDBI system will need to serve additional populations and provide core services statewide.
8. Additional revenue to serve additional populations and provide core services statewide will come from lifting county property tax caps, additional state appropriations, increased Medicaid eligibility strategies, and other sources.

RECOMMENDATIONS

1. The Commission recommends the creation of an MHDDBI fund. The purpose of the fund is to provide public funding for services and supports for eligible adults. There will be two funding components. The statewide component incorporates state and federal funds and is maintained by the Department of Human Services. It includes:
   a. A single legislative annual appropriation (the MHDDBI appropriation) in lieu of three existing appropriations (MHDD Community Services, Property Tax Relief, and Allowed Growth)
   b. State appropriations for Mental Health Institutions and Resource Centers would flow into the statewide MIDDBI fund in lieu of being appropriated to the individual facilities
   c. State appropriations for state cases
   d. State appropriations for Medicaid match for adult MHDDBI services (this state appropriation is all or part of the non-federal share, depending on the service)
   e. Federal Mental Health Block Grant (MHBG) Dollars
   f. Social Services Block Grant (SSBG) Dollars
   g. Federal Financial Participation (FFP) portion of Medicaid dollars that fund adult disability services

2. The MHDD Commission recommends establishing a county property tax levy range with a minimum and maximum rate to address the current inequalities in the property tax levies among counties. This second component of the MHDDBI fund should be maintained by each management entity. The new taxation methodology would allow a property tax levy rate range that each county could levy for the MHDDBI fund. Each county would be required to impose a standard minimum levy rate. Counties could levy above the required minimum up to the maximum allowed rate.

3. The Commission recommends distribution of state and federal MHDDBI funds to management entities using the following methodology:
   a. Determine a case rate. A case rate is an actuarially determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functionality.
   b. Calculate the total funding each management entity will need by multiplying the number of people it serves at each case rate times the case rate.
   c. Distribute to the management entity from the statewide MHDDBI fund the total minus the amount of money generated by the required minimum levy rate.
   d. Allocations to each local management unit will change as the number of individuals receiving services changes. Allocations should be recalculated quarterly.

L. PHASE-IN STRATEGY

The system changes recommended in this report are substantial and will not be accomplished overnight. The Commission envisions that the phase-in strategy that follows will implement the proposed system reforms over the course of six to eight years. The sequence of this phase-in strategy is critical. Legislation authorizing the recommended system changes must be passed in the 2004 or 2005 legislative session. Without such authorization, few pieces of the strategy can be implemented. The elements of Phase One must be in place in order to move to Phase Two, and the elements in Phase Two must be in place to move to Phase Three. See Appendix D for a chart illustrating the proposed phase-in.

PHASE ONE: JANUARY 2004 THROUGH JUNE 2005

1. The Commission recommends that county MHDDBI systems that already provide services continue to provide those services to populations they already serve throughout the phase-in. In addition, the Commission recommends that contractors under the Iowa Plan continue to provide services to populations they already serve, and that Medicaid HCBS Waiver services and other Medicaid services continue to be provided to populations they already serve.

2. The Commission recommends that the legislature:

   a. Pass legislation that authorizes all the major redesign recommendations, including authorizing the new methods of:
      - Setting case rates and distributing state and federal MHDDBI funds
      - Standardizing functional assessments and determining funding eligibility

- Assessing property tax
- Assuring delivery of core services
- Establishing a process to determine the county of residence for all persons currently receiving services so that the cost of eliminating legal settlement can be determined, both for the state and for each county.

b. Appropriate $200,000, from fund pools that are not currently allocated for services, to develop functional assessment tools and to establish case rates. This will assure that service dollars are not decreased while the redesign plan is initiated.

3. The Commission recommends that the state payment program (which provides funding for eligible individuals that do not have a county of legal settlement) begin paying for all services in county management plans.

4. The Commission recommends that the system:
   a. Implement the recommended statewide financial eligibility standards
   b. Identify sources of revenue to support statewide delivery of core services to eligible MHDDBI populations
   c. Identify how growth of the MHDDBI system impacts other social services priorities such as long-term care and health care for children
   d. Plan, collect, and analyze data to support cost estimates for serving additional populations and providing core services statewide
   e. Identify and adopt standardized functional assessment tools and processes
   f. Develop and adopt case rates
   g. Develop a strategy for improving operations of state MHIs and RCs

PHASE TWO: JULY 2005 THROUGH JUNE 2007

1. The Commission recommends that the system:
   a. Provide cost estimates for serving additional populations and providing core services statewide.
   b. Phase-in the use of new method of property taxation
   c. Phase-in the use of new method of identifying state and federal dollars for disability system funding
   d. Begin using statewide functional assessment tools and processes
   e. Begin using statewide case rates as basis for distribution of state and federal MHDDBI funds to management entities
   f. Begin using strategy for improved operations of state MHIs and RCs

2. The Commission recommends that the legislature appropriate additional MHDDBI funds, if necessary as revealed by cost estimates, to support serving additional populations and providing core services statewide in Phase Three.

PHASE THREE: JULY 2007 THROUGH JUNE 2010

The Commission recommends that the system:

1. Begin providing core services statewide to eligible individuals with mental retardation, as sufficient revenue is available.
2. Begin providing core services statewide to eligible individuals with chronic mental illness, as sufficient revenue is available. Then, discontinue serving individuals with chronic mental illness as a population category and instead provide core services to individuals with serious mental illness or serious and persistent mental illness. These are more broadly defined terms than "chronic mental illness" and thus additional individuals will be served.
3. Begin providing core services statewide to eligible individuals with brain injury, as sufficient revenue is available.
4. Begin providing core services statewide to eligible individuals with developmental disabilities other than mental retardation, as sufficient revenue is available.
5. Begin providing core services statewide to eligible individuals with mental illness that does not rise to the level of serious mental illness or serious and persistent mental illness
6. Identify and project growth/loss of MHDDBI funding in each management entity when fund distribution is no longer based on counties of legal settlement and instead is based on residence of the individuals that receive funding.

PHASE FOUR: JULY 2010 THROUGH JUNE 2012

The Commission recommends that the system begin distributing state and federal MHDDBI funds to management entities based on where the individuals receiving services reside, rather than where they have legal settlement.

CONCLUSION

The process of developing this report has been challenging and substantial. It is a product of the combined work of stakeholders across the state. The recommendations were developed through a process of consensus building to identify and suggest solutions to several persistent problems faced by individuals with disabilities, families, service providers, state and county personnel, and lawmakers. The report focuses on a few issues with broad consequences in implementing change.

The report reflects current philosophies and best practices relating to recovery and rehabilitation. Emphasis is placed on the individuals with disabilities and their active participation in the supports they receive. Individual choice and integration in the community are essential components of an effective support system. It is challenging to pursue these ideals while maintaining sufficient capacity and quality of service at state mental health institutes and state resource centers, as we try to find an appropriate balance in service options for Iowans.

A preliminary report was widely distributed and three public forums were arranged in Council Bluffs, Davenport and Des Moines prior to its final revision and adoption. The Commission reviewed the comments made and modifications were made based on the comments. The product of these public forums has been collected by the Department of Human Services, and are available on the publications section of the DHS website http://www.dhs.state.ia.us/publications.asp along with this report.

The dynamics of our current delivery system are evolving. The recommendations in this report may need to be adjusted based on changes currently taking place. An example would be changes in the Medicaid program and expansion of waiver services. The Commission respectfully requests your permission to supplement recommendations and information relating to this report as appropriate. As is apparent in Appendix C, not all the information we desired to provide is currently available. The Commission has identified specific needs and strategies to obtain this information. In addition, the sequence of the phase-in strategy is critical because each recommendation is related to other changes having been made, thus the sequential aspect of each of the recommendations. The Commission will update and append this report with fiscal information and other recommendations when available and as necessary."

For questions, comments, or additional copies of this report contact:

Becky Flores, Project Manager
DHS, BDPS Division, 5th Floor
1305 E. Walnut Street
Des Moines IA 50319
Phone: 515-281-4593
E-Mail: bflores1@dhs.state.ia.us
Fax: 515-242-6036

Information about system redesign work by the Iowa MHDD Commission, including a copy of this report, is available at:

http://www.dhs.state.ia.us/publication.asp and
http://www.dhs.state.ia.us/mhdd

APPENDIX A DEFINITIONS

BENEFIT PLANNERS are individuals authorized by the Social Security Administration to enable Social Security beneficiaries with disabilities to make informed choices about work.

BRAIN INJURY (Iowa Administrative Code 441-83.81) is the clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:
Malignant neoplasms of brain, frontal lobe
Malignant neoplasms of brain, cerebrum
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and Medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage. Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.

Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

CASE RATE. Case rate is an actuarially determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functionality.

CHRONIC MENTAL ILLNESS (Iowa Administrative Code 441-90.1) is the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

COMMUNITY SERVICES AND SUPPORTS. Community services and supports are any type of service or support needed by an individual to maintain their living environment outside of an institution.

COMMUNITY CAPACITY is the maximum amount and intensity of service a community can provide.

CORE SERVICES are those services specified in the MHDD Redesign Report Section E as key or essential to the care of MIDDBI populations to assure equity to care provision and basic care support.

COORDINATION SERVICES. See SERVICE COORDINATION.

DEVELOPMENTAL DISABILITY (Iowa Administrative Code 441-90.1) is a severe, chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the age of 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. Mental retardation is only type of developmental disability. See definition of "mental retardation".

EDUCATIONAL SERVICES are programs provided through vocational or community supported living arrangements to help an individual learn those skills necessary for daily living and/or volunteer work, and/or employment.

ELIGIBLE NON-RESIDENT means a person that meets all criteria for receiving MHDDBI funds and is present in the state, but is not a resident of any management entity.

ELIGIBLE RESIDENT means a person that meets all criteria for funding by the MHDDBI system and is a resident of a management entity.

EMERGENCY/CRISIS SERVICES (Iowa Administrative Code 441-24.4 (15) are services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress and are available and accessible, by telephone or face-to-face, on a 24-hour basis.

FACILITY (Iowa Administrative Code 441-24.4(15) means a Mental Health Institute, State Resource Center, nursing home, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), Intermediate Care Facility for the Mentally Ill (ICF-MI), or Residential Care Facility.

FISCAL INTERMEDIARIES. Fiscal intermediaries may be responsible for holding the funds for an individual's service plan. They may create payroll checks, pay invoices, track money spent, report balances every month, deduct payroll taxes from the budget, file tax forms and a pay payroll taxes. They can monitor expenditures to ensure they match the service plan. Fiscal intermediaries may conduct criminal background checks on future hires for the consumer.

FUNCTIONAL ASSESSMENT (Iowa Administrative Code 441-24.1) is an analysis of an individual's daily living skills. A functional assessment takes into consideration strengths, stated needs, and level and kind of disability of the individual.

FUNCTIONAL IMPAIRMENT means difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic living skills (e.g. eating, bathing, dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illness.

HABILITATIVE SERVICE (Iowa Administrative Code 441-78.1) is the process of training or supplying a person with the means to learn new psychosocial skills to achieve maximum independence in activities of daily living. This does not include skills a person did not learn or lost because of interference in the maturational process due to individual or parental dysfunction, that can be restored or rehabilitated. Habilitative services include performance of a function for the person. The distinction between habilitation and rehabilitation is especially important when rehabilitative treatment services are provided for persons with mental retardation.

HOMELESS INDIVIDUAL is an individual who lacks a fixed, regular, and adequate nighttime residence; or an individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. "Homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL ILLNESS (ICF-MI) (Iowa Code 135C. 1) is an institution, place, building, or agency designed to provide accommodation, board, and nursing care for a period exceeding twenty-four consecutive hours to three or more individuals, who primarily have mental illness and who are not related to the administrator or owner within the third degree of consanguinity.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION (ICF-MR) (Iowa Code 135C. 1) is an institution or distinct part of an institution with a primary purpose to provide health or rehabilitative services to three or more individuals, who primarily have mental retardation or a related condition and who are not related to the administrator or owner within the third degree of consanguinity, and which meets the requirements of this chapter and federal standards for intermediate care facilities for persons with mental retardation established pursuant to the federal Social Security Act, § 1905©(d), as codified in 42 U.S.C. § 1936d, which are contained in 42 C.F.R. pt. 483, subpt. D, § 410—480.

INDIVIDUAL BUDGET is the total dollar value of the services and supports, as specified in the person-centered plan.

INPATIENT SERVICES are services provided in a hospital setting.

MANAGEMENT ENTITY means a unit designated by and controlled by a county or a consortiums of counties that is responsible for fulfilling all local functions for the MHDDBI system.

MENTAL HEALTH INSTITUTE (Iowa Code §226.1)

1. The state hospitals for persons with mental illness shall be designated as follows: Mental Health Institute, Mount Pleasant, Iowa; Mental Health Institute, Independence, Iowa; Mental Health Institute, Clarinda, Iowa; Mental Health Institute, Cherokee, Iowa.
2. The purpose of the mental health institutes is to operate as regional resource centers providing one or more of the following:

a. Treatment, training, care, habilitation, and support of persons with mental illness or a substance abuse problem.

b. Facilities, services, and other support to the communities located in the region being served by a mental health institute so as to maximize the usefulness of the mental health institutes while minimizing overall costs.

MENTAL RETARDATION (Iowa Administrative Code 441-22.1) is

1. Significantly subaverage intellectual functioning: an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test as defined by the Diagnostic and Statistical manual of Mental Disorders Fourth Edition or subsequent editions.
2. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for the person's age by the person's cultural group) in at least two of the following areas: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
3. The onset is before the age of 18.

Mental retardation is one type of developmental disability. See definition of "developmental disability".

MHDDBI FUNDS means all revenue that comes into the MHDDBI system from federal, state, county, and other sources to be used for the benefit of eligible adults with disabilities.

MHDDBI SYSTEM means state and local entities that assure adults with mental health needs, developmental disabilities, or brain injuries can receive necessary, high quality services and supports on an equitable, timely and convenient basis, enabling them to live, learn, work, recreate and otherwise contribute in their chosen communities.

MONITORING SERVICE is a systematic review of services and activities to ensure that services are provided as approved.

NATURAL SUPPORTS means those services and supports an individual using the service identifies as wanted or needed that are provided by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public.

NET BUDGETING is a term used for the two resource centers, and selected other programs, where the state legislature appropriates “the net amounts of state moneys projected to be needed”. This is calculated by estimating the gross expenses expected for a fiscal year and deducting all non-state revenue anticipated to be earned.

OUTCOMES-BASED PERFORMANCE assures accountability by the service provider through implementation, provision, and payment for services based on pre-identified results agreed upon between the provider and the client by specifying a final goal to be achieved and makes this achievement measurable by stating objectives for the goal, each objective including what will be accomplished, the degree of acceptable achievement, and the length of time that will be given before evaluation.

OUTPATIENT SERVICES (Iowa Administrative Code 441-24.4 (14) are planned processes in which the therapist uses professional skills, knowledge and training to enable consumers to realize and mobilize their strengths and abilities; take charge of their lives; and resolve their issues and problems. OUTREACH is a process or series of activities that identifies individuals in need of services, engages them, and links the individual in need of services with the most appropriate resource or service provider.

PEER SUPPORT SERVICE is a support service provided by trained individuals that have living experience with personal disability challenges. This unique perspective provides a powerful and for many, a crucial support. Peer support services must adhere to state quality assurance guidelines and clinical supervision.

PERSONAL GROWTH AND DEVELOPMENT SERVICES are services that develop basic living skills, promote value or lifestyle clarification, develop social skills, improve problem-solving skills, encourage creative capacity and life enrichment, develop self-assurance, or otherwise aid in achieving one’s potential as an individual and a community member.

PERSON CENTERED PLANNING is a process, directed by the participant, with assistance as needed from a representative. It is intended to identify the strengths, capacities, preferences, needs and outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process. The person-centered planning process enables and assists the participant to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community settings. The identified personally defined outcomes and the training, supports, therapies, treatments and/or other services become part of the person-centered plan.

QUALIFIED ALIEN means an individual who meets the definition of "Qualified Alien" in 8 U.S.C. Section 1641.

RECOVERY-ORIENTED APPROACH (RECOVERY-ORIENTED SYSTEM). Based on hope, personal responsibility, education, advocacy, and support, a recovery-oriented approach coordinates with individuals to reach their fullest potential and societal contribution in spite of the limitations of a disability. "Recover", in this sense, means a "process of recovery" and individuals being in a "process of recovery." Recovery-orientated is not interchangeable with "cure." The positive approach of "recovery-oriented" instills hope for individuals and for the MHDDBI system.

REHABILITATIVE SERVICES (Iowa Administrative Code 441-24.1) are services designed to restore, improve, or maximize the individual's optimal level of functioning, self-care, self-responsibility, independence and quality of life and to minimize impairments, disabilities and dysfunction caused by a serious and persistent mental or emotional disability.

RESIDENT means an individual who, at the time the individual applies for or receives MHDDBI services is:

- 18 years of age or older, and
- A citizen of the United States or a "qualified alien" as that term is defined in 8 U.S.C. § 1641, and
- Living in and has established an ongoing presence in a management entity in Iowa, and not in any other management entity or state, with the declared, good faith intention of living in the unit for a permanent or indefinite period of time. A homeless individual meets this requirement.

A person does not lose residency status just because he or she is temporarily absent. Examples of temporary absences include working or vacationing out of town; serving in the military, going to school in another location, or being hospitalized or receiving treatment in another location. On the other hand, individuals have a constitutional right to move to a new location "with the declared, good faith intention of living (in the new location) for a permanent or indefinite period of time". Some individuals may be present in Iowa and otherwise eligible for MHDDBI funding but not be a resident of any management entity in Iowa. Funding for those individuals will be available through the state entity. See definition of Eligible Non-Resident.

RESIDENTIAL CARE FACILITY (Iowa Code Chapter 135C) is any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, personal assistance and other essential daily living activities to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves but who do not require the services of a registered or licensed practical nurse except on an emergency basis.

RESIDENTIAL SERVICES are services provided within an institutional setting (RCF, ICF-MR, ICF-MI). It does not include services provided within a Department of Corrections facility.

RESOURCE CENTER (Iowa Code 222.1) "The Glenwood state resource center and the Woodward state resource center are established and shall be maintained as the state's regional resource centers for the purpose of providing treatment, training, instruction, care, habilitation, and support of persons with mental retardation or other disabilities in this state, and providing facilities, services, and other support to the communities located in the region being served by a state resource center. In addition, the state resource centers are encouraged to serve as a training resource for community-based program staff, medical students, and other participants in professional education programs. A resource center may request the approval of the council on human services to change the name of the resource center for use in communication with the public, in signage, and in other forms of communication."

RESPITE SERVICES (Iowa Administrative Code 441-78.43 (3) are for temporary care to a consumer to provide relief to the usual informal caregiver and provide all of the care the usual caregiver would provide.

SERIOUS MENTAL ILLNESS (Section 1912 (c) of the Public Health Services Act). *"Adults with serious mental illness"* are persons age 18 and over, who currently or at any time during the past year have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual for mental Disorders that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. These disorders include any mental disorders (including those of biological etiology) listed in DSM-II R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-II R "V" codes; delirium, dementia, and amnesic disorders category including those related to a general medical condition; substance abuse disorders; and developmental disorders, which are excluded unless they co-occur with other diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity or disabling effects.

SERVICE COORDINATION is a function of a person or entity, either the service consumer himself or herself, a case manager, the person-centered plan coordinator of the individual, and/or the person in the management entity that is supervising the individual's person-centered plan. Service coordination is to help individuals and families develop, locate, access, and coordinate a network of supports and services that will allow them to live a full life.

STAKEHOLDERS include entities, individuals, and families that are receiving services, providing services, managing services, or funding services in the MHDDBI system.

STATE ENTITY is the MHDD Commission and the divisions within the Department of Human Services that are responsible for fulfilling all statewide functions for the MHDDBI system.

STATE CASE (Iowa Administrative Code 153.52(3) is a resident of Iowa present in the state without legal settlement in any Iowa county. In the redesigned system, a person eligible to receive services who is not a resident of a management entity will be known as an "eligible non-resident". See definition of "Eligible Non-Resident".

SUBACUTE SERVICES are those services between acute and chronic in character, especially when closer to acute. They are less marked in severity or duration than a corresponding acute state.

SUPPORT SERVICE is a service needed to maintain an individual in the living environment the individual chooses, or one that meets an individual's need within the framework of state and federal law.

UTILIZATION MANAGEMENT is a formal assessment of the medical/psychological necessity, efficacy, and/or appropriateness of services and supports requested by or on behalf of an individual. Utilization management is based on guidelines developed and/or used which serve as a way to interpret criteria of medical necessity, service necessity and psychosocial necessity.

VOCATIONAL SERVICES are activities designed to maintain or develop the person's ability to function in a job or pursue meaningful activity during the workday. The service includes activities that promote the development of skills, attitudes, and personal attributes that contribute to the person's independence "or" employment potential. Included in vocational services are those types of services that promote personal growth and development needed for basic daily living, volunteering, and employment.

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  1  1                                          HOUSE FILE 529
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  1  3                             AN ACT
  1  4 DIRECTING THE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
  1  5    COMMISSION TO MAKE RECOMMENDATIONS FOR REDESIGNING THE MENTAL
  1  6    HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES SYSTEM FOR
  1  7    ADULTS AND PROVIDING AN EFFECTIVE DATE.
  1  8
  1  9 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
  1 10
  1 11    Section 1.  MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
  1 12 SERVICES SYSTEM REDESIGN.
  1 13    In fulfilling the mental health and developmental
  1 14 disabilities commission's duty under section 225C.6,
  1 15 subsection 1, paragraph "q", the commission shall submit a
  1 16 report containing recommendations in accordance with this
  1 17 section to the governor and general assembly on or before
  1 18 December 31, 2003, for redesign of the state's mental health
  1 19 and developmental disabilities services system for adults.
  1 20 The commission shall address all of the following system
  1 21 components in the report and recommendations:

  1 22    1.  STANDARD CLINICAL AND FINANCIAL ELIGIBILITY.
  1 23    The commission shall do all of the following:
  1 24    a.  Propose a standard set of clinical and diagnostic
  1 25 eligibility requirements for use in determining which
  1 26 individuals will be covered for defined core services,
  1 27 including but not limited to, general clinical eligibility
  1 28 standards, service access criteria, level of care
  1 29 requirements, and terminology changes.
  1 30    b.  Propose financial eligibility criteria for qualifying
  1 31 covered individuals, including guidelines for resources,
  1 32 copayments, income, and assets.
  1 33    c.  Identify the total projected cost for all counties to
  1 34 adopt the standardized clinical and financial eligibility
  1 35 requirements and criteria proposed by the commission.

  2  1    2.  MINIMUM SET OF CORE SERVICES.
  2  2    The commission shall do all of the following:
  2  3    a.  Identify a minimum set of core services to be provided
  2  4 by each county.  This core set of services shall be available
  2  5 statewide.  An individual's eligibility for core services
  2  6 shall be based on consistent clinical criteria and service
  2  7 necessity.
  2  8    b.  Identify the total projected cost for all counties to
  2  9 make the core services available.
  2 10    c.  Design the core set of services as a replacement for
  2 11 the current statutory mandates for services.  The purpose of
  2 12 replacing the current statutory mandates with the core set of
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2 13 services is to shift the emphasis to community-based services
2 14 by providing covered individuals a reasonable level of choice
2 15 to meet their individual needs within available funding. The
2 16 initial set of core services considered by the commission
2 17 shall include all of the following community-based services:
2 18 (1) Mental health outpatient treatment.
2 19 (2) Inpatient psychiatric evaluation and treatment at
2 20 county-designated facilities.
2 21 (3) Service coordination and case management.
2 22 (4) Vocational services.
2 23 (5) Residential services.

2 **24 3. FUNDING FOLLOWS THE COVERED INDIVIDUAL.**
2 25 The commission shall include a process by which funding
2 26 follows the covered individual among the options considered,
2 27 including but not limited to the following:
2 28 a. Develop a new formula that allows public funding to
2 29 follow the covered individual regardless of categorical
2 30 funding. Distribution of state funds shall be based on a
2 31 matrix of disability-related reimbursement rate cells. Each
2 32 cell shall specify a reimbursement rate based on disability
2 33 group and level of functioning. The funding formula shall
2 34 take into account the number of covered individuals enrolled
2 35 in each county and the average cost of services provided to
3 1 covered individuals in each cell. The formula shall
3 2 incorporate all of the following principles:
3 3 (1) Each county will receive a quarterly allotment equal
3 4 to the product of the average costs per cell times the number
3 5 of individuals enrolled in each cell during the previous
3 6 quarter. To accommodate cash flow needs of counties and
3 7 reduce the level of fund balances counties need to maintain,
3 8 the state would make payments at the beginning of each quarter
3 9 based on the anticipated number of covered individuals, with a
3 10 reconciliation in the next quarter to the actual number of
3 11 covered individuals.
3 12 (2) Increasing overall state funding levels in proportion
3 13 to county funding levels.
3 14 (3) Allocating any increased state funding to achieve
3 15 statewide equity in service access.
3 16 (4) Allocating the state funding for state institutions
3 17 through counties rather than directly to the institutions so
3 18 that these services operate on an equal basis with other
3 19 services.
3 20 (5) Allocating state funding and administrative costs for
3 21 state cases to the covered individual's county of residence.
3 22 (6) Allocating the risk for service cost increases to the
3 23 counties and allocating the cost for increases in the number
3 24 of covered individuals to the state. Risk allocation
3 25 provisions shall address methods for managing the risk.
3 26 (7) Providing for risk management and flexibility
3 27 provisions such as cell rate adjustments, allowing waiting
3 28 lists to be used for an unanticipated increase in the number
3 29 of covered individuals, distributing quarterly allocations to

3 30 counties based upon the previous quarter's number of covered
3 31 individuals, removing categorical funding restrictions,
3 32 applying standards to ensure county cash flow capacity, and
3 33 allowing inflation adjustments.
3 34 (8) Expanding the state risk pool provisions under section
3 35 426B.5 to allow access to risk pool funding for specific
4 1 purposes and to allow counties to maintain a certain level of
4 2 fund balances in order to address certain cost factors.
4 3 b. All of the following factors shall be considered in
4 4 developing formula provisions for calculating the distribution
4 5 of funds:
4 6 (1) A county's ability to levy based on available taxable
4 7 valuation and average per capita income.
4 8 (2) A requirement for each county to have a fund balance
4 9 sufficient to cover all of the following:
4 10 (a) Cash flow for current services.
4 11 (b) Building maintenance and repair costs.
4 12 (c) Investments in new programs.
4 13 (d) A local risk pool that will cover extraordinary
4 14 expenses while a county is preparing an application to the
4 15 statewide risk pool.
4 16 (3) County costs for administration and infrastructure.
4 17 (4) Funds for counties to pay the costs of crisis
4 18 response, hospital diversion, prevention, consultation,
4 19 education, and outreach services that are provided outside the
4 20 rate cell methodology or fee payment policy.
4 21 (5) Incentives to counties for coordination,
4 22 collaboration, and infrastructure development.
4 23 c. Identify state and county costs to implement the
4 24 proposed funding formula for the individuals and services
3 25 identified under subsections 1 and 2.

4 26 **4. ADDRESS THE LEGAL SETTLEMENT PROCESS.**
4 27 The commission shall consider options for addressing the
4 28 deficiencies in the legal settlement process currently used
4 29 for determining governmental financial liability for service
4 30 costs. The options considered may include but are not limited
4 31 to providing for a transition to a system that provides for
4 32 service access based upon an individual's residency.

4 **33** **5. COORDINATION OF FUNDING STREAMS.**
4 34 The commission shall do all of the following:
4 35 a. Develop a specific approach for counties and the state
5 1 to access additional federal housing funds.
5 2 b. In consultation with counties, support new efforts to
5 3 maximize federal funding for defined core services, including
5 4 accessing federal funds to support or match county
5 5 expenditures to standardize inpatient and outpatient treatment
5 6 and hospital diversion costs for Medicaid program recipients.
5 7 c. Develop recommendations identifying the manner in which
5 8 services will be funded by the federal government, the state,
5 9 and the counties.

5 10 Sec. 2. **EFFECTIVE DATE.** This Act, being deemed of
5 11 immediate importance, takes effect upon enactment.
5 12
5 13
5 14
5 15 CHRISTOPHER C. RANTS
5 16 Speaker of the House
5 17
5 18
5 19
5 20 MARY E. KRAMER
5 21 President of the Senate
5 22
5 23 I hereby certify that this bill originated in the House and
5 24 is known as House File 529, Eightieth General Assembly.
5 25
5 26
5 27
5 28 MARGARET THOMSON
5 29 Chief Clerk of the House
5 30 Approved May 2, 2003
5 34 THOMAS J. VILSACK
5 35 Governor

APPENDIX C: COST ESTIMATES FOR SYSTEM CHANGES

Cost estimates for each section of the MHDD SYSTEM REDESIGN REPORT, or the resources needed to obtain cost estimates, are provided below. Initial costs to the system will be nominal. There will be additional costs as core services are phased in, and as additional people become eligible for services. The Commission will supplement this cost estimate as additional cost data becomes available.

ACCESS

ADDITIONAL SYSTEM COST: There will be additional costs for populations not previously served and for the expansion in outreach services.
RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Need the number of new people to be served and the average cost of outreach services.

B. FINANCIAL ELIGIBILITY

ADDITIONAL SYSTEM COST: As presently drafted, some consumers could be exempted from spending resources in order to become eligible for Medicaid. As a result, their service costs would shift to state and local funding without federal financial participation.

EXPLANATION: Currently 33 of the 99 counties in Iowa have financial eligibility standards that are less than 150% of poverty level or are unknown. There will be additional system costs associated with bringing the standard up to 150%. However, data are not available to determine the cost of implementing the proposed resource exemptions.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Approximately 40 hours of DHS staff time to analyze data currently available to DHS and an equivalent amount of time for county staff. DHS staff may need to consult individually with CPCs of counties affected because of variations in the reporting of county financial eligibility standards.

There will also be additional system costs, likely significant, if the resource guidelines are different from Medicaid and folks do not have to spend down resources to become eligible for Medicaid.

C. FUNCTIONAL/DIAGNOSTIC ELIGIBILITY – Use standardized functional assessment tools to determine eligibility for system funding

ADDITIONAL SYSTEM COST: Unknown

EXPLANATION: The Commission assumes there will be costs for

1. Developing/selecting the set of functional assessment tools to be used.
2. Ongoing use of functional assessment tools in the system.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE:

1. For selecting or developing the set of functional assessment tools to be used, costs will include
    - The time cost of knowledgeable people to select tools from those already in use by other systems, or develop our own.
    - The time cost of county and provider staff to pilot use of the tools that are selected or developed
2. For ongoing use of functional assessment tools in the system, costs will include
    - The level of professional training needed for those who administer the tool and availability of those clinicians in our system
    - Training the appropriate personnel on use of the tools
    - The cost of copyright for each use of each tool
    - The frequency of use of each tool

RESIDENCY – Will eliminate “Legal Settlement” law in Iowa as it relates to services for people with a qualifying disability.

ADDITIONAL SYSTEM COST: To be calculated

EXPLANATION: The proposal anticipates shifting responsibility for providing funding from counties of legal settlement or the state to counties of residence. It is critical that core services and standardized eligibility be in place before funding responsibility is transferred from the county of legal settlement to county of residence. The cost of implementing core services and standardized eligibility will be calculated as described in those sections.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Not applicable

CORE SERVICES: Need to consider that the system is currently not covering the costs for providing the existing services. In paragraph #3 should delete the language on "legal settlement". The State is the 100th county for determining costs for core services.

ADDITIONAL SYSTEM COST: Unknown, but assumed to be substantial.

EXPLANATION: Complete the following analysis of services:

1. Each county will analyze which of the services that the county currently delivers will be characterized as “core” under the new categorization of core services.
2. Each county and the state (for state cases) will determine how many people, by diagnosis, are currently receiving each “core service” and what those services cost.

3. Each county and the state will project how many more or less persons (by disability category) each will serve when core services for additional populations are phased in.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Unknown, will be based on the variables cited above but will require a significant amount of county and DHS staff time.

INDIVIDUALS SERVED BY THE SYSTEM: Encourages greater individual involvement in the system.

ADDITIONAL SYSTEM COST: No additional system cost.

EXPLANATION: No costs are associated with this proposal

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: None

G. SERVICE COORDINATION:

ADDITIONAL SYSTEM COST: Included under core services

EXPLANATION: Any additional costs to the system for providing service coordination to individuals that don't currently receive this service will be captured in the cost estimates addressed in section D. Thus no additional costs are addressed in this section. Costs could be less than current system because of philosophy that service coordination need not be a stand-alone service.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Not Applicable

H. MANAGEMENT ENTITIES: County or consortia of county.

ADDITIONAL SYSTEM COST: Probably some additional costs, which could be offset by seeking federal matching funds.

EXPLANATION: Most of the roles for management entities specified in this section are roles that counties are already doing. One area of enhanced responsibility will be participate in and maintain the management entity's portion of the statewide information system. Cost estimates for this function are addressed in the State Entity section, and so are not addressed here.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Not applicable

I. STATE ENTITY: Give authority to enforce; may be some positions eliminated because of work lost/to counties

ADDITIONAL SYSTEM COST: There will be a need for funds to hire additional staff plus other operating costs given the expanded duties and responsibilities of the state entity. Depending upon the final details for a new computer system (or systems) funds will be needed to develop, purchase, and operate an enhanced information technology system. A percentage of both of these may be coverable by federal match.

EXPLANATION: DHS is asked to perform additional fiscal, operational, and coordination functions in the redesigned system. DHS prepared a preliminary fiscal impact analysis of these additional functions. Staff included a division administrator, fiscal analysts, policy staff, quality assurance staff, and contracting staff. DHS must be given the resources and authority to carry out the responsibilities they are given.

Current disability system data is collected by providers, case management providers, counties, by the State Iowa Plan and Medicaid contactors (Magellan and ACS), through Medicaid systems MBC, and MMIS, through multiple other DHS data systems (individual state institutional data systems, SRS, FACS, ISIS, COMIS), and through the Iowa Department of Management. For the most part, these systems do not interface. The redesigned system will have the ability to roll up data from an individual level to meet many data analyses and reporting needs.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Additional information about the components needed for the information technology system.

I. MHIs & RESOURCE CENTERS: Clarify and focus the roles of state mental health institutions and resource centers caring for mentally retarded populations, and fund them through the management units when the dollars for the institutions go into the case rate fund.

ADDITIONAL SYSTEM COST: As community capacity is developed to support people who previously have had no alternative but the state institutions, there will be additional costs to the extent that total operating costs cannot be reduced at the same pace that census is reduced. There will also be additional costs for focusing on more difficult clientele netted against the non-difficult not being served. Individuals with high medical or behavioral needs that remain in the facilities will result in higher per diems.

EXPLANATION: DHS will have considerable additional responsibilities in developing strategic plans and fiscal systems that support the MHI and Resource Center redesign proposals. However, they are addressed in section I. above, so are not addressed here.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Not Applicable

K. DISABILITIES SERVICE FUNDING: Fund the system through balanced federal, state and county funding distributed to management units based on case rates.

ADDITIONAL SYSTEM COST: Approximately $50,000 to pay an actuarial contractor to create initial case rates through analysis of data furnished by DHS and the counties.

EXPLANATION: The proposals in this section address a new way to attribute county, state and federal funds to the disabilities system, and a new method for allocating those funds so that they are available more equitably and flexibly to those who benefit from the system. The proposals do NOT, however, anticipate any particular system costs for operation of the new funding system. The only cost would be to establish case rates.

RESOURCES NEEDED TO OBTAIN COST ESTIMATE: Not Applicable