Section Analysis of Complex Needs Bills

Update: 2/28/18

Notes (HF 2456 passed by House)	HF 2456	SF 2331	Notes (SF 2331)
Immediately terminates involuntary commitment if a person is not found to have a SUD (currently permits termination); Section 8 does this for MH commitments.	Sec. 1	--	
Allows immediate release from hospitalization w/ court notification if person with SUD no longer meets criteria; combined with Section 1, immediately frees up bed without having to wait for hospitalization hearing. Sec. 9 does this for MH commitments.	Sec. 2	--	
Allows video conference SUD hospitalization hearings. Sec. 10 does this for MH commitments.	Sec. 3	--	
Removes subacute bed cap.	Sec. 4	Sec. 1	Same.
Adds broad definition of law enforcement officer to MH information disclosure chapter (includes DNR officers, jailors, county attorneys, probation/parole officers).	Sec. 5	--	
Allows (but does not require) MH professionals disclose a patient's MH information to law enforcement ("at the minimum consistent with applicable laws and standards of ethical conduct") if made in good faith to prevent/lessen serious & imminent threat to self or others, and the patient has the intent and ability to carry out the threats. Protects against liability except if an imminent threat of physical violence is withheld (duty to disclose satisfied if make reasonable efforts to notify law enforcement).	Sec. 6	--	

Notes (HF 2456 passed by House)	HF 2456	SF 2331	Notes (SF 2331)
Changes definition of SMI to include a person who has a history of noncompliance with treatment plans which has led to hospitalizations or injury to self or others.	Sec. 7	Sec. 2	Same.
Same as Sec. 1 - for MH commitments	Sec. 8	--	
Same as Sec. 2 – for MH commitments	Sec. 9	--	
Same as Sec. 3 – for MH commitments	Sec. 10	--	
Adds oral medication to options for treatment under MH hospitalizations (current code only lists injectable).	Sec. 11	Sec. 3 & 4	Same but also requires regions to contract with professionals to provide oral and injectable medicines (currently only injectable).
Includes notification of regional MHDS contracted transportation providers when a person is discharged and requires contracted transportation providers use secure vehicles and employ staff that have or are getting MH training.	Sec. 12	--	
	--	Sec. 5	Strikes current cash flow allowances for MH/DS regions and allows 30% fund balance. Requires regions reserve anything over that for core services (then additional core if funds remain).
	--	Sec. 6	Requires MH/DS regions file quarterly reports with DHS on progress on new intensive MH services (access centers, IRSH, ACT). Regions failing to meet milestones are required to send DHS a corrective plan; DHS is to ensure corrective plan addresses deficiencies. Reports are public within 30 days.

Notes (HF 2456 passed by House)	HF 2456	SF 2331	Notes (SF 2331)
Adds *at least* 22 ACT teams and 6 Access Centers, and up to 120 beds in intensive residential service homes (IRSH) to core services and eliminates references to "initial core" services. Moves all additional core crisis services to the core list of "intensive mental health services": mobile response, 23-hour crisis observation and holding, crisis residential services, and subacute. Adds new "crisis stabilization community-based services" to the list. Eliminates regional responsibility for a 24-hour MH hotline that was listed in "additional core" (see Sec. 16, page 15 – DHS & DPH are to build a single statewide hotline on *YourLifeIowa* platform). Requires DHS to make sure core services are covered by Medicaid (subject to federal match). Requires MH/DS regions to pay for those not eligible for Medicaid (if funds available). Requires MHDS Commission to make rules for core service definitions, service provider standards, service access standards, and service implementation dates. Requires DHS to accept multi-regional agreements to provide intensive mental health services (existing crisis and new services).	Sec. 13	Sec. 7	Same except: Does not state that the numbers listed for Access Centers & ACT teams are a minimum. Requires MCOs cover core services to those eligible for Medicaid *if appropriate claims submitted* and its medically necessary. Continues to require MHDS regions administer and pay for a single statewide 24-hour crisis hotline. (SF makes this a DHS/DPH duty). Adds "warmline services" to the list intensive MH services. Does not state that IRSH services are operated 24 hours a day. In requiring DHS accept multi-regional agreements, clarifies that it is for the purposes of "determining compliance to access standards."
	--	Sec. 8	Eliminates "cash flow reduction amount" definition.
	--	Sec. 9	Strikes the requirement that regions spend down their reserves by 2020 and levy reduction if over 20% or 25% ending fund balance.

Notes (HF 2456 passed by House)	HF 2456	SF 2331	Notes (SF 2331)
Takes out levy reduction (amount over ending fund balance). Allows recalculation of per capita expenditure target if a county joins a region (= to product of new regional per capita expenditure target x county population).	Sec. 14	Sec. 10	Same.
	--	Sec. 11	Requires MH/DS region annual reports include milestones for meeting intensive MH service requirements by 7/1/21. Plans are to include implementation timeframes, processes, plans for collaboration with other regions and Medicaid, and budget).
Requires DHS and MHDS Commission to set rules for civil commitment prescreening assessments to be done in MH/DS region. Rules will address: • Prescreening by MH professional within 4 hours of emergency detention. • Coordination of services (inpatient, outpatient, subacute, detox, and community-based). • Ongoing consultations by MH professional while person is in ER. • Filing of appropriation documentation/reports.	Sec. 15	--	
Requires rules for core services to be noticed by 8/15/2018 (no emergency rules). Requires Access Center rules address/include: • Serve individuals SMI, SUD otherwise medically stable, don't need inpatient psychiatric care, but do not have safe alternatives. • No eject/reject policy. • Accept court-orders.	Sec. 16	Sec. 12	Gives emergency rulemaking authority to DHS and MH/DS Commission.

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• Dual licensure (subacute & crisis stabilization residential). • Licensed SUD provider or have cooperative agreement with SUD provider. • Provide/arrange for physical health services. • Provide navigation and warm handoffs and link with housing, employment, shelter services. • Includes bill-back provisions for inter-regional reimbursement. Requires ACT team rules: • Establish uniform statewide accreditation standards (aligned with national standards). • Prohibits MCOs from establishing standards that exceed these. • Allows bill-back to other regions. Requires IRSH rules address/include: • Licensed HCBS habilitation/ID provider • Adequate staffing and appropriate training (specifically mention ABA). • No eject/reject policy. • Accept court-orders. • Licensed SUD provider or have cooperative agreement with SUD provider. • Coordinate clinical MH & physical health. • Smaller in size (preferably 4 or fewer but can be up to 16); located in neighborhood settings. • Includes bill-back provisions. • Requires DHS provide guidance on objective utilization review criteria. Directs DHS and DPH to build upon the YourLifeIowa platform to provide a single statewide 24-hour crisis hotline that incorporates warmline services.	Sec. 16 (continued)		

Notes (HF 2456 passed by House)	HF 2456	SF 2331	Notes (SF 2331)
Directs DHS (with IDPH, MHIs, hospitals, NAMI, IBHA, and “other affected or interested stakeholders”) to review MH & SUD commitment procedures and make recommendations that increase efficiencies or more appropriately utilize the array of services (report due 12/31/18).	Sec. 17	--	
Requires DHS & IDPH (and other interested stakeholders) to review the role of tertiary psychiatric hospitals in the array of services (report due 11/30/18). Report is to include review of viability of using MHIs as tertiary care psychiatric hospitals, potential sustainable funding, and admissions criteria.	Sec. 18	--	
Asks Legislative Council to convene a study committee to analyze the viability of MH/DS regional funding, including levies, budgets, per capita expenditure targets, and fund balances (report with recommendations by 1/15/19). Made up of 5 Senators (3 Rs, 2 Ds), 5 Representatives (3 Rs, 2 Ds).	Sec. 19	--	
Directs DHS to amend its rules to require bed tracking system include both adult and child co-occuring subacute beds.	Sec. 20	--	
Directs DHS to review reimbursement rates for ACT and make recommendations by 12/15/18.	Sec. 21	--	
Allows DHS to implement rules (not emergency).	Sec. 22	--	