



# Champaign County Developmental Disabilities Board (CCDDDB) Meeting Agenda

**Wednesday, March 19, 2025, 9:00 AM**

*This meeting will be held in person at the Shields-Carter Room of the  
Brookens Administrative Building, 1776 East Washington Street, Urbana, IL 61802  
Members of the public may attend in person or watch the meeting live through this link:  
<https://us02web.zoom.us/j/81559124557> Meeting ID: 815 5912 4557*

- I. **Call to order**
- II. **Roll call**
- III. **Approval of Agenda\***
- IV. **CCDDDB Meeting Schedule ([posted here](#)) and CCMHB Meeting Schedule ([posted here](#)) and Allocation Process Timeline (as "CCDDDB Important Dates" among [public documents here](#)) are for information only.**
- V. **CCDDDB Acronyms and Glossary are [posted here](#) for information only.**
- VI. **Citizen Input/Public Participation See below for details.\*\***
- VII. **Chairperson's Comments – Ms. Vicki Niswander**
- VIII. **Executive Director's Comments – Lynn Canfield**
- IX. **Approval of CCDDDB Board Meeting Minutes (pages 3-6)\***  
*Action is requested to approve the minutes of the CCDDDB's February 19, 2025 meeting.*
- X. **Vendor Invoice Lists (pages 7-9)\***  
*Action is requested to accept the "Vendor Invoice Lists" and place them on file.*
- XI. **Staff Report (pages 10-43)**  
*Included for information only is a report from Lynn Canfield. Other staff reports are deferred due to review of requests for funding.*
- XII. **New Business**
  - a) **Evaluation Capacity Building Project (pages 44-52)\***  
*A decision memorandum provides an overview of the Evaluation Capacity Building project and requests a two-year extension. Additional details are attached.\**
  - b) **PY2024 Service Activity Data (pages 53-67)**  
*For information only, a briefing memorandum presents full year claims data, with analysis of utilization per program and by selected individual cases.*
  - c) **Results of Agency Survey (pages 68-77)**  
*For information only, a briefing memorandum introduces results of recent survey.*
  - d) **Review of Applications for PY2026 Funding (pages 78-79)**  
*For information only, the packet includes a list of PY2026 I/DD funding requests and a checklist for (optional) Board member use.*

- e) **Input from People with I/DD** (pages 80-81)  
*Feedback shared with staff or board members is presented for information only.*

**XIII. Old Business**

- a) **Response to Emerging Threats** (pages 82-89)  
*The Board may discuss formal responses to threats to the safety and stability of people with I/DD and other vulnerable residents. To support discussion, two articles from Disability Scoop are included for information only.*
- b) **Engage Illinois**  
*An oral update will be provided on the statewide system redesign effort.*
- c) **disAbility Resource Expo Update** (pages 90-93)  
*Save the Date flyers and project financials are included for information. An oral update will be provided.*

**XIV. Successes and Other Agency Information**

*The Chair reserves the authority to limit individual agency representative participation to 5 minutes and/or total time to 20 minutes. See below for details.\*\**

**XV. County Board Input**

**XVI. Champaign County Mental Health Board Input**

**XVII. Board Announcements and Input**

**XVIII. Adjournment**

*\* Board action is requested.*

*\*\*Public input may be given virtually or in person.*

*If the time of the meeting is not convenient, you may communicate with the Board by emailing [stephanie@ccmhb.org](mailto:stephanie@ccmhb.org) or [kim@ccmhb.org](mailto:kim@ccmhb.org) any comments for us to read aloud during the meeting. The Chair reserves the right to limit individual time to five minutes and total time to twenty minutes. All feedback is welcome.*

*The Board does not respond directly but may use input to inform future actions.*

*Agency representatives and others providing input which might impact Board actions should be aware of the [Illinois Lobbyist Registration Act, 25 ILCS 170/1](#), and take appropriate [steps to be in compliance with the Act](#).*

*For accessible documents or assistance with any portion of this packet, please [contact us](#) ([kim@ccmhb.org](mailto:kim@ccmhb.org)).*

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**CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT  
OF PERSONS WITH A DEVELOPMENTAL DISABILITY  
(CCDDB) MEETING**

*Minutes February 19, 2025*

*This meeting was held at the Brookens Administrative Center  
1776 E. Washington St., Urbana, IL 61802  
and with remote access via Zoom.*

**9:00 a.m.**

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**MEMBERS PRESENT:** Kim Fisher, Vicki Niswander, Anne Robin, Neil Sharma (remote), Susan Fowler

**STAFF PRESENT:** Kim Bowdry, Leon Bryson, Lynn Canfield, Chris Wilson

**OTHERS PRESENT:** Jessica Smith, Jodi Harmon, Heather Levingston, AJ Zwettler, Annette Becherer, Sarah Perry, Jami Olsen, Laura Bennett, Danielle Matthews, Patty Walters, DSC; Becca Obuchowski, Community Choices; Angela Yost, CCRPC; Jacinda Dariotis, Rachel Jackson-Gordon, UIUC; Mel Liong, Michelle Ingram, PACE; Brenda Eakins, GROW; Jenny Lokshin, County Board; and (closed session only) Joel Fletcher, State’s Attorney

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**CALL TO ORDER:**

Ms. Niswander called the meeting to order at 9:00 a.m. CCDDB member Dr. Neil Sharma requested to attend remotely due to employment obligations. In compliance with the CCDDB By-Laws a motion was requested by Ms. Niswander to allow his remote attendance.

**MOTION: Ms. Niswander moved to allow remote attendance for Dr. Neil Sharma for this meeting due to employment obligations, as allowed in the CCDDB By-Laws. Dr. Robin seconded the motion. All CCDDB members voted aye and the motion passed.**

**ROLL CALL:**

Roll call was taken, and a quorum was present.

**APPROVAL OF AGENDA:**

An agenda was approved.

**CCDDB and CCMHB SCHEDULES/TIMELINES:**

Updated copies of CCDDB and CCMHB meeting schedules and CCDDB allocation timeline were posted.

**ACRONYMS and GLOSSARY:**

A list of commonly used acronyms was posted.

**CITIZEN INPUT/PUBLIC PARTICIPATION:**

None.

**PRESIDENT’S COMMENTS:**

Ms. Niswander made brief comments concerning the review process.

**EXECUTIVE DIRECTOR’S COMMENTS:**

Director Canfield introduced Jenny Lokshin from the Champaign County Board. She made some brief comments.

**APPROVAL OF MINUTES:**

Minutes from the 1/22/25 meeting were included in the packet.

**MOTION: Dr. Robin moved to approve the 1/22/25 board meeting minutes, with the correction of adding Kim Fisher as present at the meeting. Dr. Fowler seconded the motion. A voice vote was taken and the motion passed.**

**VENDOR INVOICE LIST:**

The Vendor Invoice List was included in the Board packet.

**MOTION: Dr. Robin moved to approve the Vendor Invoice List as presented. Dr. Fowler seconded the motion. A voice vote was taken and the motion passed unanimously.**

## **STAFF REPORTS:**

Reports from Kim Bowdry, Leon Bryson, Stephanie Howard-Gallo, and Chris Wilson were included in the packet.

## **NEW BUSINESS:**

### **Review of Applications for PY2026 Funding:**

For information only, the packet included a briefing memorandum on the process of reviewing requests for funding, with a checklist for (optional) Board member use. A list of successful applications was attached.

### **Input from People with I/DD:**

Feedback shared with staff or board members was included in the packet for information only. Kelli Martin, DSC, spoke to the board, reading input from self-advocates.

## **OLD BUSINESS:**

### **Response to Emerging Threats:**

Dr. Fisher requested a monthly discussion of vulnerable community members who may no longer receive federal benefits in the future. An article from “NEA Today” was included in the packet.

### **Engage Illinois:**

A section of justadollap.org relevant to Engage Illinois efforts was included in the Board packet for information only. Ms. Niswander provided a verbal update on their activities.

### **Evaluation Capacity Building Project Update:**

An oral update was provided by Rachel Jackson-Gordon from the Evaluation Team.

### **disAbility Resource Expo Update:**

Deferred.

### **PY2025 Second Quarter I/DD Program Activity Reports:**

For information, service activity reports from funded I/DD programs were included in the board packet.

### **PY2025 Second Quarter Service Claims Data:**

For information only were summaries of service claims from many I/DD programs.

## **SUCSESSES AND AGENCY INFORMATION:**

Kelli Martin from DSC spoke about “Spread the Word”. Becca Obuchowski from Community Choices commented on transportation issues and options. Patty Walters from DSC introduced new employees and position changes within the agency. AJ Zwettler from DSC shared activities.

**COUNTY BOARD INPUT:**

None.

**CCMHB INPUT:**

The CCMHB will meet this evening.

**BOARD ANNOUNCEMENTS AND INPUT:**

It was decided to cancel the March 26, 2025 meeting.

**Other Business - Closed Session**

**MOTION:** At 9:51 a.m. the Ms. Niswander moved to enter Closed Session Pursuant to 5 ILCS 120/2(c)(11) to consider litigation which is pending against or on behalf of Champaign County, and litigation that is probable or imminent against Champaign County. The following individuals joined the closed session: members of the Champaign County Developmental Disabilities Board, Executive Director Canfield, Associate Director Bowdry, and Assistant State’s Attorney Joel Fletcher; and to enter into Closed Session for Semi-Annual Closed Session Minutes Review Pursuant to 5 ILCS 120/2(c)(21). Dr. Fowler seconded the motion. A roll call vote was taken and the motion passed. Dr. Robin and Dr. Sharma recused themselves from the Closed Session.

The Board returned to open session at 10:28 a.m. with a roll call vote.

**MOTION:** Ms. Niswander moved to accept the February 19, 2020, February 26, 2020, July 21, 2021, and February 23, 2022 closed session minutes as presented, to continue maintaining them as closed, and to destroy the recording of the February 23, 2022 meeting. Dr. Fisher seconded. A vote was taken and the motion passed unanimously.

**ADJOURNMENT:**

The meeting adjourned at 10:30 a.m.

Respectfully Submitted by: Stephanie Howard-Gallo,  
CCMHB/CCDDB Operations and Compliance Specialist

*\*Minutes are in draft form and subject to CCDDB approval.*

# Champaign County, IL

## VENDOR INVOICE LIST



INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER										
Feb '25	DD25-078	02/01/2025	020725A	42592	34,903.00	34,903.00	02/28/2025	INV	PD	DD25-078 Decision Supp
CHECK DATE: 02/07/2025										
10146 COMMUNITY CHOICES, INC										
Feb '25	DD24-076	02/01/2025	020725A	42632	2,833.00	2,833.00	02/28/2025	INV	PD	DD24-076 Staff Recruit
CHECK DATE: 02/07/2025										
Feb '25	DD25-075	02/01/2025	020725A	42632	17,791.00	17,791.00	02/28/2025	INV	PD	DD25-075 Self-Determin
CHECK DATE: 02/07/2025										
Feb '25	DD25-077	02/01/2025	020725A	42632	14,250.00	14,250.00	02/28/2025	INV	PD	DD25-077 Transportatio
CHECK DATE: 02/07/2025										
Feb '25	DD25-090	02/01/2025	020725A	42632	17,750.00	17,750.00	02/28/2025	INV	PD	DD25-090 Inclusive Com
CHECK DATE: 02/07/2025										
Feb '25	DD25-095	02/01/2025	020725A	42632	19,958.00	19,958.00	02/28/2025	INV	PD	DD25-095 Customized Em
CHECK DATE: 02/07/2025										
10170 DEVELOPMENTAL SERVICES CENTER OF										
Feb '25	DD25-080	02/01/2025	020725A	42647	25,666.00	25,666.00	02/28/2025	INV	PD	DD25-080 Individual an
CHECK DATE: 02/07/2025										
Feb '25	DD25-081	02/01/2025	020725A	42647	51,250.00	51,250.00	02/28/2025	INV	PD	DD25-081 Community Liv
CHECK DATE: 02/07/2025										
Feb '25	DD25-082	02/14/2025	021425A	42928	79,166.00	79,166.00	02/28/2025	INV	PD	DD25-082 Community Fir
CHECK DATE: 02/14/2025										
Feb '25	DD25-083	02/01/2025	020725A	42647	43,375.00	43,375.00	02/28/2025	INV	PD	DD25-083 Service Coord
CHECK DATE: 02/07/2025										
Feb '25	DD25-084	02/01/2025	020725A	42647	21,666.00	21,666.00	02/28/2025	INV	PD	DD25-084 Clinical Serv
CHECK DATE: 02/07/2025										
Feb '25	DD25-085	02/01/2025	020725A	42647	8,208.00	8,208.00	02/28/2025	INV	PD	DD25-085 Employment Fi
CHECK DATE: 02/07/2025										
Feb '25	DD25-086	02/01/2025	020725A	42647	20,333.00	20,333.00	02/28/2025	INV	PD	DD25-086 workforce Dev
CHECK DATE: 02/07/2025										
Feb '25	DD25-091	02/01/2025	020725A	42647	41,666.00	41,666.00	02/28/2025	INV	PD	DD25-091 Community Emp
CHECK DATE: 02/07/2025										
Feb '25	DD25-092	02/01/2025	020725A	42647	9,583.00	9,583.00	02/28/2025	INV	PD	DD25-092 Connections
CHECK DATE: 02/07/2025										

72,582.00

# Champaign County, IL

## VENDOR INVOICE LIST



INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
Jan '25 DD25-082	02/14/2025	01/01/2025	021425A	42928	79,166.00	79,166.00	02/28/2025	INV	PD	DD25-082 Community Fir
10424 PERSONS ASSUMING CONTROL OF THEIR ENVIRONMENT INC.					380,079.00					
Feb '25 DD25-079	02/07/2025	02/01/2025	020725A	42724	3,831.00	3,831.00	02/28/2025	INV	PD	DD25-079 Consumer Cont
Jan '25 DD25-079	02/07/2025	01/01/2025	020725A	42724	3,831.00	3,831.00	01/31/2025	INV	PD	DD25-079 Consumer Cont
					7,662.00					
18 INVOICES					495,226.00					

\*\* END OF REPORT - Generated by Chris M. Wilson \*\*

# Champaign County, IL

## VENDOR INVOICE LIST



INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER										
Feb '25	IDDSI25-089	02/01/2025	020725A	42593	19,336.00	19,336.00	02/28/2025	INV	PD	IDDSI25-089 Community
CHECK DATE: 02/07/2025										
OCAFY24	FUND2101 GC	02/26/2025	022825A	43353	1,306.03	1,306.03	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
OCAFY24	FUND2101 TA	02/26/2025	022825A	43364	113.68	113.68	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
					20,755.71					
3 INVOICES					20,755.71					

\*\* END OF REPORT - Generated by Chris M. Wilson \*\*

# Briefing Memorandum

Date: March 19, 2025

To: Members, Champaign County Developmental Disabilities Board (CCDDB),  
Members, Champaign County Mental Health Board (CCMHB),  
Champaign County Executive and Members, Champaign County Board (CCB),  
Members, Association of Mental Health Authorities of Illinois (ACMHAI)

From: Lynn Canfield, Executive Director, CCDDB and CCMHB, and  
Legislative Committee Co-Chair, ACMHAI

Re: **Legislative & Policy Conferences** of National Association of Counties (NACo) and  
National Association of Behavioral Health and Developmental Disabilities Directors  
(NACBHDD)

From March 1 through March 6, 2025, I participated in sessions of the Legislative and Policy Conferences of NACBHDD and NACo, along with their board meetings. Below are notes from these sessions and meetings, with some links to additional information which may be of interest.

I have been active with NACBHDD and NACo for ten years, currently serving as Vice President of NACBHDD, new board member of NACo, and member of NACo Healthy Counties Advisory Board, Resilient Counties Advisory Board, Stepping Up/Familiar Faces, and Health Policy Steering Committee. So much of the good work being done in Champaign County informs these policy platforms, especially for community-based care for people with intellectual and developmental disabilities (I/DD), very young children and their families, youth with multi-system involvement, and people who have behavioral health needs and justice involvement.

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## NACo Health Steering Committee

*Discussion of timely health policy issues relevant to counties, such as addressing hunger as a social determinant of health, youth mental health, and cybersecurity in healthcare settings, and to consider policy resolutions to shape NACo's federal advocacy.*

**Chair Phyllis Randall** made opening comments, welcomed new members, introduced committee and subcommittee leadership, and reviewed the agenda.

### ***“Federal Partner Spotlight: US Dept of Health and Human Services”***

**Darcie Johnston**, newly appointed Principal Deputy Director, Office of the Secretary, Office of Intergovernmental and External Affairs, U.S. Dept of HHS.

- The US healthcare system is failing, chronic disease skyrocketing, .e.g. The system treats symptoms rather than disease, need new initiative with radical accountability.
- MAHA commission will have a 100-day report on what is making people sick and then a strategy to restore health. No more industry-controlled research. Fund studies

- on why disease is rising; promote healthy food in partnership with farmers; focus on prevention not pharmaceuticals.
- Priorities: end the COVID 19 mandates (let parents make decisions), lower drug prices, cost transparency, withdraw from WHO due to mismanagement of COVID, no taxpayer funded abortion, no transgender surgery, a Starlink investment to help manage the system. This is an opportunity to transform healthcare and rebuild trust.
- Need the help and collaboration of counties.

### ***“Safeguarding Support for Home and Community Based Care”***

*Medicaid-funded home- and community-based services (HCBS) are essential lifelines for millions of individuals, including those with IDD, older adults, and people with complex medical needs. As HCBS continues to expand access to care, fostering community integration and reducing reliance on institutional settings, proposed Medicaid cuts threaten to weaken these vital services. This panel examined the broad-reaching implications of Medicaid funding reductions, including increased strain on the direct care workforce, rising per-user costs and growing disparities in service availability across states... strategies to advocate for sustainable funding and policy solutions that protect and strengthen HCBS for all who rely on them.*

**Greg Puckett**, Mercer County, WV, introduced panelists and moderated.

**Matt Salo**, CEO, Salo Health Strategies

- Overview of Medicaid and how HCBS and waivers relate. Managed Care not as typical with the long-term care IDD and complex support needs, although Managed Long Term Supports are increasing.
- Congressional debate to finance tax cuts but balance this with cuts to programs. Local and state governments are not likely to be able to pick up the difference if these funds are reduced. Millions of people rely on these programs, as do their families.

**Stephen McCall**, Director of Research, PHI

- Particular impact on the workforce, across levels of service intensity, from institutional to home care. Home Care Workers support people with daily activities, independence in the community, health support, and link to care teams, which can prevent ED visits. Daily social supports are especially important in view of the loneliness epidemic.
- Majority of workers are women, Black, Hispanic/Latino, and not acknowledged for their role. While not highly credentialed, their work is very important.
- Demand for this workforce has more than doubled in one decade, will grow more than any other occupation (700k+ new jobs) in the next decade, while 4.8 m workers will leave the field in this time, with total job openings projected at 5.5m.
- Highly challenging work, even disabling in some cases. Job quality is misaligned with this demand, and median hourly pay is \$16.13.
- 46% work part time, with \$22k median annual, 40% in low-income households, and 58% rely on public assistance, including 36% with Medicaid coverage.
- The work has lots of windshield time and logistical barriers to full time work. 2/3 of spending on this type of care is from HCBS which was enhanced the last few years,

when states have had extra funding which ends next week. Medicaid has a big role in financing and shaping these jobs.

- The high cost of steep Medicaid cuts will be: less funding for care and jobs; reduced access to coverage for workers; rippling economic impacts. Federal Medical Assistance Percentage (FMAP) reductions are on the table. Work requirements are challenging. Significant impact on local economies. Is the greater burden from taxes or from care gaps? <https://PHInational.org> has workforce data center, per state.

**Lisa Harootunian**, Director of Health, Bipartisan Policy Center

- Balancing accountability, fiscal responsibility, and HCBS access: in 2021, 44% of Long Term Services and Supports (LTSS) spending was Medicaid; in 2020, \$124.6b (62.5%) was spent on HCBS and \$74.8b (37.5%) on institutional services; over 4m people rely on HCBS (an optional benefit), and demand is rising, longstanding shortage of direct care professionals.
- Federal policy solutions to these challenges? The system is very complex and burdensome for states to administer and for individuals to navigate, and there are great inequities within and between states. How can the program work better without causing loss of services? Key challenges to the workforce shortage are inadequate support for direct care staff, untargeted workforce programs reducing the number of new workers, and insufficient data which limits policymakers' ability to understand and address the shortage.
- Create sustainable, supportive environments: strengthen transparency and oversight of payment rates and compensation; national study on relationship between enhanced FMAP and workforce; National Health Care Workforce Commission funding to perform comprehensive evaluation of the health care workforce; establish a refundable tax credit for caregivers, up to \$3k for LTSS expenses.
- Grow the # of new workers: strengthen recruitment and training; increase # of permanent employment-based visas and expedite the visa process; implement a legalization program for qualifying foreign-born workers, e.g., a minimum 180 days of direct caregiving labor over last two years; create certified direct care worker status which is valid for 5 years and renewable, toward lawful permanent resident status.
- Improve data on workforce characteristics, emphasizing the need for reforms, clarity about the unpaid workforce. [lhootunian@bipartisanpolicy.org](mailto:lhootunian@bipartisanpolicy.org)

**Questions:**

*How to promote awareness, given the heightened fear and anxiety?*

- Acknowledge that Medicaid is a government program (federal PLUS state and local); rather than expecting people to understand how these all work together, be clear that big changes will impact most of us, in ways not always obvious. Do the best you can with available data.

*What can be done for those not eligible for Medicaid and therefore with no support?*

- There is not a long-term care policy nationally, and because Medicaid is a low-income needs-tested program as our default, you don't get care until you have impoverished yourself to qualify. This wouldn't exist if we had a sensible, humane policy. LTSS are expensive, and while HCBS is a more affordable alternative, it's an optional program, and states may have to reduce access to its services in order to

manage their own spending. Uncertainty about what is going to happen, esp as per capita caps offers savings but create a significant risk of loss of services.

### ***“Roundtable Discussion: Advancing Collaborative Care through Federal Policy and Intergovernmental Partnerships”***

*... to advance Collaborative Care—the integration of mental health, behavioral health and substance use treatments into primary care... federal policy can enhance this model, improve care coordination and strengthen partnerships among counties, states and federal government.*

**Chair Randall** offered a brief overview of integrative care and the role of counties in facilitating integrative care as owners and operators of health and mental health systems.

### ***“Federal Support for Integrative Care: Implementing the IBH Model in MI”***

**Julia Rupp**, CEO, West Michigan Community Mental Health

- Overview of Centers for Medicare and Medicaid Services (CMS) Innovation in Behavioral Health (IBH) Demonstration Program.  
<https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model>
- Few states applied for this opportunity due to other innovations. Most efforts focus on whole-person care, with recent interest in addressing social needs. An 8-year cooperative agreement, with CMS heavily involved for technical assistance (TA), plus financing support, though not a great amount.
- Care Delivery Framework includes conveners who implement and provide the structure and addresses how to integrate all federal Medicaid efforts into this one, including health homes, behavioral health homes, and Certified Community Behavioral Health Clinics (CCBHCs) Outpatient services plus primary care. Additional funding directly to the practice participants. Value-based Medicare payments. Data exchange across all parties.
- Michigan’s implementation and the role of county/local mental health facilities role in implementing the model: built on what they already have, lots of CCBHCs and an early adopter of Value Based Care (VBC), though only on the behavioral health side. The heavy lift is creating VBCs that include physical healthcare savings. Smaller providers, e.g., of support for housing, food, and other health-related social needs, are struggling. While there are shared care plans, we can’t see Medicare data and often not substance use disorder (SUD) data.
- Elements of the model that can be adapted by local governments for enhanced integrative care: replicate the ‘convening’ structure; expand current ones to include all who need to be at the table to talk about the whole person; for population needs assessment, some counties use the one the hospitals create; identify metrics that are important to your community; use value-based payments (VBP) to pay for outcomes.

#### **Break-out Discussion Questions:**

##### *1. Funding & Reimbursement Models*

- How have existing Medicaid waivers (e.g., 1115, Health Homes) supported integrated care in your county, and where are there gaps in eligibility, funding, or implementation?

NACO and NACBHDD 2025 Legislative and Policy Conference Session Notes

- What challenges do counties face in transitioning to value-based payment models, and how could federal policies better support this shift?
2. *Workforce & Capacity Building*
    - What federal workforce programs (e.g., loan repayment, telehealth funding) have been most effective in expanding integrated care teams, and what additional supports are needed?
    - How could federal policies better support the use of community health workers and peer support specialists in integrated care models?
  3. *Data Sharing & Care Coordination*
    - What barriers do counties face in sharing behavioral health data due to privacy regulations (e.g., 42 CFR Part 2), and what changes would improve care coordination?
    - How effective are current federal efforts to promote interoperability, and what additional policy changes are needed to facilitate seamless data sharing?

### **Group Report-Outs.**

Our reports back to the full group were very similar: we should emphasize that this work already focuses on efficiency and eliminating waste and fraud; we believe in continuing with the innovations already in place (through waivers, etc.); workforce challenges loom over all of the work; support for behavioral health is broad; need to improve the sharing of data for care coordination and for proving success; need rates structure, including for peer supports; focus on prevention, health related social needs, cost shift data, and return on investment (ROI.)

## **NACO Health Steering Committee Business Meeting**

### ***“Panel Discussion: Health Priorities in the 119<sup>th</sup> Congress”***

*Bipartisan Congressional policy staff on priorities for key committees in the 119th Congress.*

**Chair Randall** spoke on counties’ role in healthcare and Medicaid financing, introduced the panel, and posed questions for discussion.

### **Panel Q&A:**

*With lots of work on behavioral health reform, where is bipartisan agreement for action and policies?*

**Charlotte Rock**, Senior Health Policy Advisor, Senate Committee on Finance (Majority).

- Update on approval of nominations. Good history of bipartisan wins on the Senate side, accomplishments in mental health (MH) and SUD last year. A lot of work in front of us, including healthcare in rural communities, long term payment stability, cost transparency, underlying issues with chronic disease, etc. Focus on budget reconciliation right now, with a narrow window for Senate. How to make Medicaid run more efficiently, esp concern about the growth rate in Medicaid. Safe Harbor for Provider Taxes is one solution being considered. Transparency in how much states can use to draw down federal funds. Streamline programs, make them more efficient.

**Joshua Sheinkman**, Staff Director, U.S. Senate Committee on Finance (Minority).

- Good timing, as federal funding runs out in two weeks. Short term patches are not cutting it, as providers need more stability and security. Hope to pass and adopt within long term funding for Congress. Provisions we worked on to lower drug prices were thrown out in December. Need to work on rural, MH/SUD, etc. Democrats are not invited to the table for the two budget bills where Medicaid and other safety net programs are on the chopping block.

**David Jurbala**, Defense Fellow, Rep. Gerry Connolly (D-VA)

- Veterans care legislation “Not Just a Number Act” would increase data collection on veteran suicide, expand to all VA benefit programs. Better education may be less of a financial burden.

*Given challenges in health care system, esp the much-needed home health care workforce, many of whom are undocumented or have temporary status, what is the intersection between these?*

- Charlotte: Senate committee doesn’t have jurisdiction over immigration policy, but we know the workforce issues went from bad to worse during the pandemic. Regulatory relief esp for rural, leveraging telehealth and other digital health options, let us know what’s working well for you.
- Joshua: boss focuses on behavioral health, esp youth residential facilities “Warehouses of Neglect” with maltreatment. A bill to invest in community-based access, care. With immigration, even people legitimately here and working have been swept up.
- David: (to a question about veteran PTSD, getting into the system, and high rates of suicide loss) – reducing wait times and increasing education about available care are critically important because even two weeks is too long for many. Funding MH providers in the community, enabling veterans to access them through the community, and building up that network. Hope to reauthorize the grant program for two more years and increase the funding for it.

*How do we have policy solutions to improve access to healthcare in rural communities (hospital and community care), workforce, and infrastructure?*

- Joshua: threats of Medicaid cuts will hit folks across the country, including rural residents. It supports children, elderly, people with disabilities, rural members, all of the most vulnerable. Need money to maintain existing programs let alone the expansions. Keep raising concerns with your congressmen and senators. Hospitals are often the economic drivers locally so their closure can be devastating.

*Any studies about the impact of cutting preventive services, leading to higher costs and worse personal health outcomes, esp rural? How much \$ they save, etc.*

- Charlotte: boss knows Medicaid serves a high need population, but we need to look at Medicaid and make sure the dollars are being spent most effectively. We need to have the hard conversations about what works and doesn’t work. NACO can keep making recommendations on streamlining SNAP and Medicaid programs.

*How can counties leverage resources to reduce veteran suicide?*

- David: help people navigate VA bureaucracy; rural residents don’t always have good access to services, so support facilities through Medicaid funding.

*Given how important the federal government is to our work, how do we collaborate to shape policies that improve health and well-being?*

- David: military community and congressman Connolly appreciate NACO.
- Charlotte: know who is working on what, learn from us how the policies work.

- Joshua: meet with your elected officials using specific examples and have them visit facilities within their jurisdictions, more effective than reading about them.

### ***“Committee Business Meeting”***

*Health Resolutions and Platform Changes Received Within 30 Day Deadline: Policy resolutions are generally single-purpose documents addressing a specific issue or piece of legislation. Resolutions draw attention to a topic of current concern, clarify parts of the broadly worded platform, or set policy in areas not covered by the platform. Resolutions and platform changes are valid until NACo’s 2025 Annual Conference. “Emergency” resolutions are federal legislative or regulatory matters that could not have been foreseen 30 days prior to the conference. Steering committees receiving these may consider them only if two-thirds of the steering committee members present vote to review them.*

**Chair Randall** reminded that the NACO Platform is different from Interim policy resolutions, reviewed the standards for policy resolutions, that their focus is federal, and that the background is not part of the policy.

**Barry Buchanan**, Whatcom County, WA, served as parliamentarian and prompted the resolutions sponsors to introduce each.

#### [Proposed Interim Resolution Declaring Food Security in Rural Areas a Public Health Priority \(Health Steering Committee, Agriculture and Rural Affairs Steering Committee\)](#)

Sponsor Barry Buchanan: amendments striking some background, to focus on support for existing federal programs, supply and distribution of healthy food, and planning for permanent structural solutions. Friendly amendment accepted. One member read national evidence of the benefits of healthy food in early life for later disease prevention and good health. *PASSED.*

#### [Proposed Interim Resolution in Support of Increased Funding for Uterine Fibroid Education, Research and Treatment](#)

Sponsor Donna Miller, Cook County: background, with data, additional risk to Black women, funding to improve maternal mortality and health outcomes for all women. High cost of fibroid treatment. Moved and seconded. Chair thanked cook county and Hon Miller for this. *PASSED.*

#### [Proposed Interim Resolution in Support of Preventative Health](#)

Sponsor Bill Lowry, Cook County: for preventive care and screenings at no cost to uninsured patients, promote research and innovation to enhance early detection. Counties cover such services using 40-50% of their budgets. Will promote decreased costs in long term care, longer life, etc. People with insurance have access to these. Positive fiscal impact on all counties. Some discussion, praising preventive health care, thanking the sponsor, discussion of costs counties bear as safety net payer and in the long term higher cost needs for less preventive care. *PASSED.*

#### [Proposed Interim Resolution Clarifying Treatment of Distinct Facilities Located on the Same Campus under Federal IMD Law](#)

Sponsor Steve Ding, San Joaquin County, CA: to clarify that up to 10 institutions (of different types, e.g., hospitals, nursing facilities, other) can be located on the same campus but not combing the number of beds across facilities for the purpose of evaluating whether an institution

is an IMD. Friendly amendment was accepted. Discussion of main body of resolution to clarify this is in addition to other NACO resolutions related to IMD. *PASSED*.

[Proposed Interim Resolution on Securing Increased Reimbursements to Pharmacies and Other Healthcare Providers in Rural Communities \(Health Steering Committee, Agriculture and Rural Affairs Steering Committee\)](#)

Sponsor Julie Ehemann, Shelby County, OH: aging population versus access to pharmacies and health care due to unfair insurance practices. Discussion: thank you to the sponsor; should include compounding or any other reimbursable services because we need better reimbursement for everything; definition of a ‘pharmacy dessert’ includes 10-mile radius. *PASSED*.

[Proposed Interim Resolution on Eligibility of Veterans with Non-punitive Other Than Honorable Discharges for Health Benefits \(Human Services and Education Steering Committee, Health Steering Committee\)](#)

Sponsor James Zenner, Director, Dept of Military and Veteran Affairs, LA County, CA: esp discharges which could be linked to various traumas experienced in service, with some rates doubled over those of Vietnam era, because discharges keep them from accessing VA care. Question about ‘other than honorable’ if sexual misconduct, how to determine if related to trauma. Amendment to include reversal of all dishonorable discharges, including posthumous, due to ‘don’t ask don’t tell’ and reinstate all benefits, as this issue has not been fully addressed. Question about transgender vets. Question about people who had childhood PTSD. Procedural point – the primary committee was Human Services so they will have to accept the amendment. The amendment passed. Motion and second of the amended resolution. *PASSED*.

[Proposed Interim Resolution to Reduce the Frequency of Reevaluations for Home and Community-Based Services \(HCBS\)](#)

Sponsor: Barb Brekke, Scott County, MN. Esp with initial and annual evals for those with HCBS, which is not realistic for those with DDs. Reduce to every three years or upon request or if there is a significant change. *PASSED*.

**Emergency resolutions** must have policy implications and been unforeseen 30 days ago, require 2/3 majority vote to consider, and have separate consideration with simple majority to approve.

Proposed Emergency Resolution on Expanding Prescribing Authority to Include Advanced Practice Nurses.

Sponsor Ben West, Clackamas County, OR. For CMS to expand reimbursement and prescribing authority. Discussion on whether to consider: PAs fighting for this for years, but big pushback from medical community while the need related to MH keeps growing; corrections to the policy statement (nurse practitioners and physician assistants) 2/3 majority vote allowing it to be considered. With the rules suspended, vote to approve the resolution *PASSED*.

Proposed Emergency Resolution on Medicaid Cuts.

To urge congress to protect Medicaid for our most vulnerable residents by preventing harmful funding cuts that will equate to massive cost shifts to counties while collaborating with counties to reduce demonstrated waste, fraud, and abuse. Discussion – block grant would be a cut, so

that's included. 2/3 majority vote allowing it to be considered. With the rules suspended, vote to approve the resolution *PASSED*.

### ***“Advocacy Agenda & Congressional Meeting Preview for the 2025 Legislative Conference”***

*Committee liaison Blaire Bryant... on key advocacy priorities for the committee based on the discussions taking place at the meeting, and the committee policy priority survey... federal policy agenda, highlight critical issues counties will bring to Capitol Hill, and offer guidance on effective congressional engagement... legislative developments and strategic insights.*

- Review of policy priorities - Preventing Harmful Medicaid Cuts is one. Congress has a tough job finding \$880m in savings, but Medicaid is a tough place to take it. Per capita caps would limit funding per beneficiary, straining state and county resources and leading to hospital closures. Work requirements do not bring big savings and are hard for beneficiaries and add administrative burden for states and counties. Reduced FMAP will cause loss of coverage for millions, increase medical debt, and increase uncompensated care costs for providers. The Medicaid Fiscal Accountability Rule (MFAR) is back and would reduce local ability to raise their share of reimbursement.
- Other priorities of the Health Committee: fund federal rural health programs under FORHP; strengthen Medicare and Medicaid; incentivize rural health professionals; expand rural telehealth. Ongoing: addressing the Medicaid Inmate Exclusion policy, building the health care workforce, building local crisis infrastructure, protecting funding for public health services, and improving health care access and equity.
- Bipartisan mental health priorities in the 119<sup>th</sup> Congress are Youth Mental Health, Medicaid IMD Reform, and Opioid Overdose Prevention.

## **NACO Healthy Counties Advisory Board Meeting**

**Hon. Janet Thompson**, HCAB Chair and Commissioner, Boone County, MO

- Introduced the topic of food as medicine, food insecurity, importance of chocolate (fair trade dark sample provided), introduced leadership and thanked sponsors. In her most prosperous school system, 70% of children are on free/reduced lunch. Stigma and negative health outcomes. Food insecurity is increasing, but counties can implement targeted solutions, such as food banks with services, public health screening to include questions about food, and coordination of effort.

### ***“Counties and Food Insecurity”***

*Food insecurity and the lack of access to affordable and nutritious food often corresponds with poorer health outcomes and increased risk for chronic health conditions.*

**Aaron Goldstein**, Senior Manager, Local Government Relations, Share Our Strength

- 14m children live in food insecure (FI) households, trend rising. In 2023, 13% of all households were FI. 17% of those with children were FI. Rates higher for households with children, 34% if run by single mother, 26% for Hispanic families; 1 in 5 children lived in FI households in 2023.

- In 2021 a record low of FI, mostly due to increased SNAP benefits and enhanced child tax credit, but when the programs ended in 2023, the rates rose again, so we know that government programs work. States with high OR low SNAP participation can experience high rates of FI. Rural communities very vulnerable.
- Congress is considering SNAP and Summer Electronic Benefit Transfer (EBT) cuts, which will drastically increase rates. Protect access to SNAP. Summer is the hungriest time of year for children; parks rec lunch only reaches 1 in 7; grocery benefit program for summer can help; bulk meal pickup for rural communities (USDA) can provide 14 days of meals at a time; not all states participate in these helpful programs, some run through community action or education. American Public Human Services Corp offers supports. Align SNAP and other efforts.

### ***“Integrating Food and Nutrition Supports into Other Systems of Care”***

*County governments, as administrators of programs for low-income residents, are uniquely positioned to foster cross-systems collaboration. By integrating food and nutrition supports into a variety of settings, county leaders can increase access to and awareness of the resources that combat food insecurity.*

**Julie Hiatt, VP and General Manager, Population Health, Netsmart**

- Not just access to food but what kind of food. Background on what Netsmart does for counties’ technology needs, across the care continuum.
- 50% of variations in health and mortality are related to social determinants of health (SDOH). 21% of those experiencing homelessness reported mental health symptoms. Integrate across supports (healthcare, schools, libraries) to eliminate care siloes.

**Breakout Discussion** recommendations for data sharing and health/justice coordinating council.

## **NACO Midsize County Caucus Exploratory Committee Meeting**

*... focus on establishing key priorities and objectives to guide the caucus's efforts in advocating for the unique needs of midsize communities.*

**Hon. Gary Moore, Judge/Executive, Boone County, Ky.**

- Introduced the topic and co-chairs, who discussed their hopes for the task force.
- 56% of counties fit in this category, have both urban and rural issues, etc.
- Each task force member shared insights: suburban/urban areas with transition to rural; large or rural caucus meetings informative but not always a fit; many midsize counties are growing, have ag and tourist industries; some gain population from rural neighbors, often due to their loss of healthcare providers and other resources; some have universities as the economic driver; some manufacturing increasing, with stress on public services like fire dept; growth and development are common concerns.
- On NACO’s to do list for a long time, and the Exec Committee now needs to act.

**Brett Mattson**, Legislative Director – Justice & Public Safet

- Purpose of exploratory committee, potential impacts of a formal Caucus to enhance NACo advocacy efforts and membership engagement. Quick turnaround, hopefully ready by Western Interstate Region meeting. (This meeting room was packed.)

### ***“Open Member Discussion on Goals & Priorities”***

*Challenges facing midsize counties... potential priorities and structure of the caucus.*

- Concerns about competitive funding; homelessness in communities outside the population center, how to serve folks effectively; transportation barriers; lack of affordable housing, and cost of housing driving homelessness; water, including threats to sole source aquifers, wastewater management, and new demands; can't access USDA rural development funds for rural areas due to total population, so some larger counties may fit better here due to not being monotypic and benefiting from policy priorities developed through this group; pollution including of waterways; broadband connectivity is a basic utility now but many of our communities do not have adequate capacity yet; mental health and opioid use issues; climate change and climate disasters including loss of usable coastal land to salt from seawater; increased partnerships across local and state and federal governments, with discrepancies per jurisdiction; system is taxed by some programming; loss of hospitals, and helicopters can go fast enough; community development block grants (CDBG) important, though some thresholds may no longer be appropriate; how to build economic opportunities where there is decrease of farmland (tax policies, innovations to attract good jobs); looking for help to continue cleaning up contaminated sites with loss of EPA support; air quality across communities and states; emergency managers say it's not always worth filing for disaster funding; wealth disparities and the need for economic development opportunities requiring a high tech STEM workforce; non-attainment zone problems with electricity generation, need tax abatements or incentives to allow power companies to transition to newer technologies.
- NACO leadership joined us to affirm the group's importance. Less about size and more about the mix and interaction of rural, urban, and suburban qualities, and the limits that impact mid-size counties due to this mixture.
- Task force discussion of population size parameters and name. LUC and RAC are redefining their own documents now, so some of the questions related to complexity versus size will be sorted out. The group's ability to meet will also depend on sponsorship funding. Mid-size and Metropolitan Areas (MMA or MAMA), applying to 923 counties potentially. Subcommittee organization within the broader committee. Purchasing partnerships. This special purpose task force will end, and input from today will be used by NACo staff to create a structure and priorities one-pager (for review in April), proposal to the board in May, hope to start with next fiscal year and possible inaugural meeting at annual meeting. NACo president will appoint chairs as they do with RAC and LUC. Focus some workshops on the needs of this group.

## **NACO Session**

## ***“Federal Immigration Policy Impacts on Counties”***

*Impacts of recent and proposed changes to immigration policy on local economies... how these policy shifts may influence workforce availability, economic stability, and service delivery in affected sectors, with a focus on the child care and agriculture workforces, as well as counties as employers... workforce needs and local economies amid evolving immigration policies.*

**James O'Neill**, Director of Legislative Affairs, American Business Immigration Coalition

- Workforce and Immigration Solutions. ABIC is bipartisan, seeks ethical solutions.
- Review of changes to work authorization programs: resolution in both chambers to repeal extensions made by the prior administration shorten the runway for renewal documents; temporary protected status ended for 300K Venezuelans so their work authorizations are ending; ending Temporary Protected Status (TPS) for others, e.g., El Salvadoreans here for over 30 years; ended two programs of prior admin (work auth as part of parolee status); changes to asylum and refugee system are being considered; refugee resettlement program was closed but reopened in a limited fashion; several changes in enforcement of immigration law, including the end of sensitive zones so that churches, hospitals, schools are now open to enforcement; mandatory indefinite detention for those even accused of a crime, e.g., theft.
- Disruptions in workforce: in CA, many not showing up to work, not just among undocumented laborers but also those with a family member at home who might be.
- Reduced foot traffic in Hispanic areas of cities, even among people with legal status.
- Increased workplace enforcement. DHS has two ways to enforce immigration law at a business, including county government: I9 form audits (work auth verification) leading to fines; oversight raid searching for individuals, with follow-up audit.
- Social Security ‘no match’ letters may go out, but mismatches can result from many types of error; don’t fire people based on these, can be a civil rights violation.
- Severe workforce crisis across industries already, with millions of workers needed. Immigrants are 1/3 of hotel staff, up to 80% of restaurant workers; undocumented workers are a significant portion of hospitality, construction, food, etc. The impacts of raids on communities and local economies are very significant, with ripple effects.
- Reforms supported by ABIC: permanent residency for Dreamers (DACA is likely to be terminated); legitimate asylum claims – expand eligibility for seasonal workers, there are 3X as many applications as approved each year; the average undocumented worker has been here 8 years, paying taxes, so those with no criminal record should remain in the workforce; support the President’s ideas for permanent green card to all who graduate a US university and a solution for dreamers. <https://abic.us/>

**Samantha Ayoub**, Associate Economist, American Farm Bureau Federation

- Farm Bureau has 6m members. Labor shortages have been exacerbated.
- Structural changes in rural communities, as populations become both older AND younger, increasing the need for child care and elder care.
- 40-45% of ag workers are undocumented; 17% of these work in ag, the largest proportion; temporary worker programs are 10 months max; still need hand workers in these fields; administrative complexity is a barrier for H-2A temporary ag workers, and fewer than 10k American workers apply for these jobs.

- Rise in use of third party labor contractors to bring people into the country to do these jobs, renting people out to different farms during the year.
- H-2B non-ag workers do landscaping and food processing, part of ag supply chain.
- Adverse effect wage rate, unpredictable wage raises. Admin costs before wage costs are also high. If these were domestic workers, would save over \$300k per year in admin costs. Increases in application costs; H-2A wage rule has changed. Certification changes and required payment rates change if certain activities are included in the work (i.e., driving a tractor) even if not all hours in the 40 hr week.
- No workforce solutions. Cost-prohibitive to farmers. May have to import food.  
<https://www.fb.org/>

**Anne Hedgepeth**, Senior VP of Policy and Research, Child Care Aware

- Childcare resource and referral systems. Data, professional development, serving as hubs in their communities. Childcare and early learning a mixed group, including multi-site, center and home based, private and public. 624,300 childcare businesses in 2022. A large part of the economy, employing about 1.5m people.
- 25% of children birth to 5 are in immigrant families; 5.2m children have at least one undocumented parent, but 4.4 children are US citizens.
- Childcare workforce is 22% immigrant, foreign-born women. Big impacts from policy changes due to big gap already, not meeting needs of all children and families.
- How childcare is funded: much of the cost is picked up by parents; local, state, and federal funding for childcare and development programs, with different names per state, combining state or local match with federal; block grants with conditions related to the child; state and local governments can choose to serve more and pay for that, e.g., Head Start, migrant and seasonal Head Start. Some federal funding streams come with requirements which impact this.
- Changes to enforcement - no more sensitive zones, including childcare settings. Great concern for impact of trauma on children. <https://www.childcareaware.org/>

**Karl Eckhart**, VP State and Local Government Affairs, National Association of Home Builders

- Oversees state and local advocacy resources for home-builders associations, and administering State and Local Issues Funds (SLIF).
- The raids are real. ICE comes to the jobsite looking for one person, and then no one shows up for the next five days.
- It takes 28 different trades to build a house. Most builders employ one person, and the rest are subcontracted. Immigrants are crucial to the trades. 30% are immigrants.
- We need more workers to build more homes and then help the price of homes decrease. Need more visas to avoid competing with ag. More training of young people to come into residential construction. Look at CONSTRUCTS Act  
<https://www.congress.gov/bill/118th-congress/senate-bill/4980>
- <https://www.nahb.org/>

**Questions:**

*Local govts plan for natural disaster response, but do we have a plan to respond to the unprecedented crisis of so many children worried for their parents?*

- Free public trainings on employer rights and responsibilities related to documentation and protecting people and businesses, partnering for legal services, planning for childcare and guardianship and even pickup from school.

*Afghan asylum seekers plus women still there or waiting in Pakistan, in dangerous situations, so is there a pathway for uniting those families and keeping our promise to our Afghan allies?*

- Outside the panel's control, hoping for a bipartisan bill they'd urge congress to pass.

*Children are in that position because of decisions their parents made, so families should put plans in place for long term care for their children - what are you doing to train them to do this?*

- H-2A workers are often trying to take financial opportunity back to their home country. Employers have a risk related to pointing people out, so they do better to advocate for legal pathways and access. Business sector has been asking for immigration reform for 25 years, so we need the help of electeds to move it forward.
- During COVID, immigrants working in food (meat processing) were essential workers in very high-risk settings so the new threat is an injustice.

*Is there movement to get dairy separated, since it takes two years to become a skilled laborer?*

- Farm Workforce Modernization Act - <https://www.congress.gov/bill/118th-congress/house-bill/4319>. The 10-month rule with H-2A is simply a regulatory decision, as 'seasonal' is not a major part of the act, mentioned only once, so year-round work should and could be included. Attempted to address this for 37 years. Need to create pathways for citizenship or remaining long-term, with expansions to H-2A to ensure that we don't end up back in this situation, for ag and all industries.

## NACo Board of Directors Forum

**Amanda Karras**, Local Government Legal Center (LGLC).

- Overview of LGLC, which focuses on the Supreme Court and federal courts.
- Some impacts on SCOTUS so far, filing briefs related to local authority/autonomy and then expansion of liability: the filing on Grants Pass (criminal citations for homeless encampment, public camping should be a local policy matter) is often cited by SCOTUS; offers guidance on Lindke v Freed Case (local govt employees and officials on social media and when you are running afoul of first amendment protection) so we can train people on this, and the court zeroed in on the LGLC test which was based on authority (use disclaimer, etc.)
- Ten more important cases relevant to local govts, mostly about limiting liability. Wins in Lackey v Stinnie (limiting attorney fees) and in EMD Sales v Carrera (limiting overtime exemptions.)
- Highlight San Francisco v EPA, whether the Clean Water Act allows EPA or similar entities to impose generic prohibitions. Compliance with permits shields from liability and penalties. EPA put in some non-specific generic prohibitions. SF wanted clarity. The Ninth Circuit sided with EPA. Implications for local govts are high penalties for violations, so by the time it gets to SCOTUS, it will have been costly.
- LGLC Education includes summaries on SCOTUS findings and webinars including on the federal Executive Orders. <https://imla.org/local-government-legal-center/>

**NACO President James Gore, CEO Matt Chase, and Amanda Karras**, on Executive Orders.  
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- Temporary restraining orders on the full-scale funding freeze. States having trouble because the order was enforced. Judgement related to it upheld the restraining order.
- Two buckets: state and local govt with existing federal contracts already signed, and you did the work and wait for reimbursement, but some are paused for various reasons (no appointed cabinet secretary at the time, related to DEI, or other); congress has appropriated the money to agencies who have not yet awarded it to contracts, and these could be impounded and not spent (though Nixon was blocked from doing this) but there is no budget for this fiscal year yet. Call your federal agency and ask why your money is held up and develop a solution, possibly rewriting the grant agreement.
- Broadband program of last administration didn't work, money is still sitting there.
- Discuss what we need, including ARPA-like investments.
- Expect and hope for clarification from the SCOTUS.
- Majority of ICE detainer requests are voluntary, warrantless, hold up to 48 hours.
- The themes of these executive orders will be a big part of our work going forward. We will get a review of the 70 and then track them.

**Mark Ritacco and Eryn Hurley on NACO Proposed Resolutions.**

- Four resolutions relate to immigration (birthright citizenship, ensuring continuation of legal asylum, reinstating Cuban-Haitian-Nicaraguan-Venezuelan process, and other.)
- Review of the resolution review and approval process.
- Due to years of close margins in Congress, many things are getting done through executive orders.
- In the current fiscal year which began Oct 1, 2024, we are still operating under continuing resolutions, with this one to expire March 14. Complicated by Republican one seat majority and federal funding freeze, causing Democrats to push back more.
- A disaster supplemental could move by itself, but this is also newly politicized due to question of the role of Federal Emergency Management Agency (FEMA) and subsequent review counsel. We do want more clarity, quicker reimbursements, etc., as counties cannot recover without assistance from other govt. Historically bipartisan but now complicated.
- The budget reconciliation (required, not discretionary) is a big deal now, with trillions of dollars difference between revenue and spending.
- NACO's Short-Term Federal Priorities are Disaster Reform, Secure Rural Schools, Counties and Medicaid, Tax Exempt Municipal Bonds, County Human Services. Lots of detail on each, with e.g., potential costs down the line if municipal bonds are not exempt (average \$6500 increase in homeowner tax bill.) These are at risk because by eliminating the tax-exempt status, the federal govt would raise an est \$364bn in new federal revenues. This IS private investment in infrastructure, as the federal govt has nothing to do with it. Market-driven voter approved infrastructure improvements.
- Tax cuts have to be fed by a different area, as there are no new revenue areas. The discretionary budget submitted by the President to Congress is the biggest part. The laundry list of items released in 40-50 pages, with provisions stored for budget impact for years, among which they'll probe for weakness and see who objects.
- House Budget Plan v Senate Budget Plan: they need to come to a consensus on one bill to send to the President for approval, which is still being worked out.

- On the ‘cutting’ side, they need \$1.5 trillion in cuts over ten years, but they really want \$2 trillion. Each committee has a number to cut. House Energy and Commerce has been given a number, and nothing else they do comes close to Medicaid spending.
- Even though not all counties have a direct role with Medicaid, all states do. Counties with hospitals and nursing homes are even more vulnerable. Many have indigent care responsibilities. Cost-cutting ideas include converting Medicaid to a block grant program, to per capita cap, or changing state match requirements; each option has been coming off the table. Every state has a provider tax for health care providers and hospitals – they tax and then give them the higher reimbursement rate back. Removing these would add the need for states to cover from general funds.
- Lots of conversation about healthcare overall. 25% of Americans get healthcare through Medicaid. Of the 79m, 37m are children (comprising 40% of all US children). The vast majority of these children have parents with health insurance through work. Progress on behavioral health, much of which is through Medicaid. How do we tackle rural Emergency Medical Services (EMS)? What happens to rural hospitals? 15% of rural provider revenue comes from Medicaid.
- We understand the federal debt is not sustainable. We are trying to be an intergovernmental partner and think this through, not simply shifting costs.
- Board members should focus on these webinars and share with state associations.
- No projection on these plans for reducing the debt.

## NACo Board of Directors Business Meeting

**President Gore** called to order, introduced prayers and speakers.

Invocation given by **Hon Bernard Carvalho Jr**, Councilmember, Kauai Co, HI.  
Pledge of Allegiance led by **Hon JD Clark**, NACO First VP.

### ***“Intergovernmental Affairs Update from the White House”***

Special remarks by **Alex Meyer**, new Director of the White House Office of Intergovernmental Affairs, and his deputy director, **Christine Serrano Glassner**.

- Deputy Director Glassner was a mayor until Jan 20, with lots of experience working with counties. She sees much room for growth and improvement in counties. She and her team will be available to help solve our problems at the federal level. “Let us be your guide when it comes to federal agencies.”
- Director Meyer understands how important counties are, focus on ‘bottom up.’ He intends to put pressure on federal agencies to turn around major issues which impact us, said these agencies have a lot of emails and phone calls unanswered, and wants them to do better. What comes from states and counties needs to be handled first.
- Dep Dir Glassner reminded all of the federal expo within NACo’s meetings.

**President Gore** led approval of minutes, nominations to NACO board of directors, reports from the Audit Committee and Finance Standing Committee (approved by voice vote), and appointment of Matt Prochaska to parliamentarian.

***“Proposal to recognize a new Affinity Group, the National Association of Native County Officials and Allies.”***

**Hon Lena Fowler**, Supervisor Coconino County, AZ.

- Background on this national peer network.
- Statements on why it will matter were offered by officials from Minnesota, Hawaii, and Montana. Positive comments from board members.
- Motion to recognize this affinity group was approved by voice vote.

***Standing Committee Reports***

- President Gore, Credentials and Nominating Standing Committee
- Hon Renee Couch, Membership Standing Committee – 85% of counties, parishes, etc are represented
- Hon Greg Puckett, Programs and Services Standing Committee – strengthen outreach to newly elected officials.
- Hon. Greg Weiss, IT Standing Committee – cybersecurity remains top concern, AI integrated with other priorities, website accessibility, emergency technologies.
- Counties are 2% of the US Workforce.

**Business meeting adjourned.**

***Board convenes as the Resolutions Committee.***

*For those with NACO website access, the full text of proposed resolutions is available here - <https://naco.sharefile.com/share/view/s745b7a37f0584b7a8df050481f3ad4a3>  
If you do not have access, please contact me for details.*

**AGRICULTURE AND RURAL AFFAIRS STEERING COMMITTEE**

*Approved cross-claiming of two resolutions with other committee’s resolutions.*

**COMMUNITY, ECONOMIC & WORKFORCE DEVELOPMENT STEERING COMMITTEE**

Proposed Interim Resolutions on: Community Development Block Grant – Disaster Recovery Program Permanent Reauthorization; Community Development Block Grant Program Reauthorization; Ensuring Non-discrimination Practices in the Federal Government (*this was pulled from consent agenda and discussed later*); Homelessness Assistance; Incentivizing Production of Housing Through Federal Tax Code; and Supporting the Use of the Federal Government’s Uniform Appraisal Dataset in Assessments. *Approved all but the one.*

**ENVIRONMENT, ENERGY & LAND USE STEERING COMMITTEE**

Proposed Interim Policy Resolutions on: Permitting Reform Policy; Supporting PFAS Passive Receiver Protections for Local Governments; Opposing the Department of Energy National Interest; and Electric Transmission Corridors (NIETC). *Approved.*

**FINANCE, PENSIONS & INTERGOVERNMENTAL AFFAIRS STEERING COMMITTEE**

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Proposed Interim Resolutions on: Supporting the Continued Role of Federal Entities in Election Assistance for Counties; and Urging Congressional Action to Exempt Poll Worker Pay from Federal Taxes *Approved.*

#### **HEALTH STEERING COMMITTEE**

Proposed Interim Resolutions: Clarifying Treatment of Distinct Facilities Located on the Same Campus under Federal IMD Law; Declaring Food Security in Rural Areas a Public Health Priority; in Support of Increased Funding for Uterine Fibroid Education, Research and Treatment; in Support of Preventative Health; on Securing Increased Reimbursements to Pharmacies and Other Healthcare Providers in Rural Communities; to Reduce the Frequency of Reevaluations for Home and Community-Based Services (HCBS); and Emergency Resolutions Expanding Prescribing Authority to Include Advanced Practice Nurses and on Medicaid Cuts. *Approved.*

#### **HUMAN SERVICES & EDUCATION STEERING COMMITTEE**

Proposed Interim Resolutions on: Eligibility of Veterans with Non-punitive Other Than Honorable Discharges for Health Benefits; Ensuring a Clear and Fair Vetting Process for Migrants; Ensuring the Continuation of Asylum; Federal Agencies Respecting and Granting Protection to “Sensitive Locations”; Protecting Safety Net Programs from Harmful Cuts; Protecting Section 1 of the 14th Amendment of the US Constitution and Ensuring the Right to Birthright Citizenship; and Reinstating the CHNV (Cuban, Haitian, Nicaraguan, and Venezuelan) Parole Program. *Approved. The committee asks that more Republican members become involved.*

#### **JUSTICE & PUBLIC SAFETY STEERING COMMITTEE**

Proposed Interim Resolutions to: Advocate for the Restructuring and Strengthening of the Federal Emergency Management Agency (FEMA); and Support the Adoption of a Damages Cap on Federal Civil Rights Claims. *Approved.*

#### **PUBLIC LANDS STEERING COMMITTEE**

Proposed Interim Resolutions: Encouraging Federal Land Management Agencies to Utilize Existing Studies and Promote Efficient Siting of Infrastructure Projects; on Allowance of 'Mechanized' Equipment as Appropriate in Wilderness by the U.S. Forest Service; on Wildfires; Opposing Nationwide Resource Management Planning & Supporting Federal Land Management Agencies Amending Plans Locally at the Field Office and Forest Unit level; and to Codify Federal Agency Adherence to the Administrative Procedures Act. *Approved.*

#### **TELECOMMUNICATIONS AND TECHNOLOGY STEERING COMMITTEE**

Proposed Interim Resolutions on: 911.gov Program Reauthorization; and Funding for 911 Public Safety Emergency Telecommunications. *Approved.*

#### **TRANSPORTATION STEERING COMMITTEE**

Proposed Interim Resolutions: in Support of Federal Support for Federal Safety Standards for Lithium-Ion Batteries in Micromobility Devices; in Support of Transportation Project-Specific Permitting; and Reform in FY2026 Surface Transportation Reauthorization Legislation. *Approved.*

Discussion of Proposed Interim Resolution Ensuring Non-Discrimination Practices...

- This had been overwhelmingly approved by the steering committee, with 6 or 7 opposing votes. The cosponsors, David Stout and Sarah Benatar, provided overview. One who opposed the vote spoke to the process, that things should be worked out prior to going in front of all.
- Discussion of process. Pulling things off the consent calendar/agenda is not always negative, just that more discussion will be beneficial. As many speaking for as against? Yes, 3 comments on each side. No further point of order discussion.
- Next to the substance. The EO doesn't change federal laws, protected classes are still protected. Motion/second/discussion: opposition - this is superfluous and political; North Carolina members have left NACO due to feeling it was partisan, so this reads like using NACO as a political tool (suggests using 2/3) so that we will not be perceived as a united voice; if there is no non-discrimination language in fed contracts but we as a county adopt such lg, there could be a conflict; notes that the 1960s EO was rescinded therefore no longer has programs or practices in place to ensure non-disc – is this true?; can fed agencies even reinstall the programs? And does this apply to everything we do or e.g., roadways?
- Remanded back to the committee to answer questions for the annual meeting.

### ***“State of Mental Health Policy in America”***

Special remarks by **former U.S. Senator Roy Blunt (R-MO)**.

- Collaborated with Senator Debbie Stabenow for a dozen years, esp on mental health.
- Community mental health centers one solution. They took the Community Mental Health Act (CMHA), the last bill signed by JFK, back to the floor 50 years later and pointed out that the cost of institutional care was to be shifted to community care way back then. Treating mental health saves money later. Treat it like physical health.
- The model requires several services 24/7. Started with 10 pilot states, of which 9 have continued and tracked data to show whether this is true, also alleviating pressure on emergency rooms and police departments. In MO, they save \$579 per Medicaid client. The police and sheriffs have a place to take someone. People with mental illness are more likely to be the victim of a crime than the perpetrator.
- Senators Blunt and Stabenow used these positive results from the pilots to advocate for permanent funding (and savings) and to allow the other 40 states to do this... 60 years after the CMHA was signed and made the commitment. NIH data on MI.
- Blunt also chaired the appropriations committee. Telehealth is another important innovation. There is at least one CCBHC in each of 46 states.
- <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics>
- His bipartisan work with Sen Stabenow was historic, so we gave a standing ovation.

### ***Caucus Reports***

- Large Urban County Caucus (LUCC), **Hon. David Crowley**, Chair reviewed priorities: support resilience, workforce, disaster preparation (collab with state and fed), and advance economic stability. LUC fly-in will be in DC and symposium in Milwaukee County.

- Rural Action Caucus (RAC), **Hon. Lena Fowler**, Chair spoke of leadership development, regional partnership, creative funding, and solving the housing issue.
- Western Interstate Region (WIR), **Hon. John Peters**, First VP on public lands work.

**Matt Chase, CEO.**

- Thanked the exec committee and board for all of their work keeping the association together during tough times. Thanks to Mark Ritacco for overall planning, all the staff for their work.
- NACO Blueprint for 2030 will be presented in May and July, to build an inclusive organization that sticks to our lane of the county's role in intergovernmental work.
- National trends in state level policy. How to harness expertise and purchasing powers to drive the US forward from the grassroots up.

## **NACBHDD Spring Board Meeting**

**Kyle Kessler, KS**, Past Chair did call to order, introductions, and meeting overview.

**Dave Kisher and Chris Cotton**, Netsmart

- Update and efforts related to data infrastructure for CCBHCs, health homes, IBHs.
- Leading conversations around technology that reduces the burden of multiple tech providers, pulls the right data, and can be shared with partners across systems.

### ***Keynote Presentation***

**Daniel Chao**, Head of CAO Coach/Congressional Staff Academy and former Chief of Staff

- CAO Coaches was launched in 2021, after the House authorized a plan to create a new office to train House members and staff in how to do their work, modernization of congress. The group includes 4 former Chiefs of staff, 2 former district directors, with 125 combined years of experience, nonpartisan/bipartisan, offering confidential coaching and panels based on the needs.
- Prepping for a shutdown. Then for working with the budget you have. New member orientations. Private website with templates, samples, tip sheets, video content, 101-style tutorial series, position specific pages, and 'life as a staffer.'
- May develop a similar support for Senate staffers.
- Calendar with deadlines related to communications, legislative, external/official will influence your goals - when/how to tackle, when to move on, pause, or nix and move on. Staff are navigating unprecedented levels of calls and visits from angry, anxious constituents. District outreach and engagement is critical, rethinking how to engage with federal agencies; these folks are the first to have data, info, stories. New constituencies that weren't involved. Previously unaligned or less engaged press.
- White House/Executive Branch Engagement. Don't neglect local, regional, and state entities that still need to work with the member's office.
- Legislative. Leverage for caucus memberships; report language; bipartisan engagement (limited but still exists).
- Communications, present in every other category; amplify and receive comms, monitor constituent trends; phone logs and constituent letters are important.

- Internal Office Structure/Housekeeping. Follow-up, what to give back, self-care, recruitment and training of interns and fellows, knowing members' needs and preferences to avoid having to backtrack when a member changes their minds, what you can influence and what you can't, where you can be flexible and where you can't.
- Bountiful Opportunities Exist!

**Jonah Cunningham**, NACBHDD CEO reviewed fact sheets, toolkit, policy platform, meetings.

### ***Committee and Affiliate Reports***

- Past President Kyle Kessler, KS – Jonah's review and contract; appreciation of Bob Sheehan and Cheryl Ramirez for getting us through difficult years and transitions.
- NACo Board Representative – Lynn Canfield, IL – summary of meetings.
- I/DD-Jonah on behalf of Adam Herman, OH
- Behavioral Health and Justice-Annie Uetz, IA
- Directors of State Associations Committee (DSAC)-Kyle Kessler, KS
- Strategic Planning Advisory Group-Rene Hurtado, TX
- National Association of Rural Mental Health (NARMH)-Shauna Reitmeier, MN

### ***Strategic Planning Update***

**Jonah C. Cunningham/Christopher Wimbush**

- Four Foundational Units: Board Governance, Staffing & Infrastructure, Marketing & Brand Identity, Partnerships & Membership
- Implementation of plan: Interim Policy Platform, Policy Advocacy Toolkit, Increased Conference Attendance, Leverage Technology to Assist Staff
- The process of developing the plan went well, a good start for us. If the board reviews alignment with the plan, staff will know that's their priority. It is relevant to the day-to-day work. Annual plans can help, but so much can't be done in one year. A two- to four-year Strategic Plan can support flexibility and be a filter for saying no. Possible committees for governance.
- Strategic plan updates at future board meetings. Possibly two conferences a year.

***CLOSED SESSION*** – variety of business.

## **NACBHDD L&P Conference**

### ***“State of the States in 2025”***

*Policies that start on the federal level are often implemented on the state and local levels. Compounding this is that each state has a unique culture and political make up which can demonstrate in different approaches to behavioral health and I/DD policy.*

**Bob Sheehan, MI**, received a certificate of appreciation, introduced the panel, and moderated.

**David Coe, VA**, Colonial Behavioral Health in Williamsburg

- Local Community Services Boards (CSB), serving the historic triangle. Our CSB is the quasi-governmental provider of BH and DD services for the region. VA has five regions, all members of the Virginia Association of CSBs. Proud to be plugging along but find ourselves in unimagined times.

**Jinny Palin, MN, Minnesota Association of Community Mental Health Programs (MACMHP)**

- As it's only been 9 years, surprised to be thought of as seasoned. Currently 38 members. One of several statewide associations but with the broadest scope, providing a continuum of MH services.

**Kyle Kessler, KS**

- Represent 26 now-CCBHCs around the state. Had 998 rather than 988. Having all members going in the same direction has helped. Challenges in bigger regions.

**Adam Herman, OH**

- Lead the association of county boards of DD. Ohio is unique in separating DD boards from county behavioral health authorities. Primarily fund services through property taxes (1.5bn) and share Medicaid burden with the state, which pays 55% of match, and have a say in the services. Some urban metro DD boards have BH programs.

**Discussion of priorities.**

- Jinny: some continue as before the election: investments, Medicaid rates reform, ensuring licensed providers can focus on direct care by streamlining regulations. MN was one of the first six CCBHC states, has codified it as a benefit in their state plan, and hope to continue to evolve it. SAMHSA criteria included in the state plan so it would be harder to change. Building up national data by sticking to the model. Since the election and budget forecast, keeping an eye on the federal threats, but the budget will be in the red in 2026 and 2027, so shift to policy work. The Medicaid rates reform would cost half a bn (all outpatient fee-for-service categories.) MN will likely be a 50/50 split, and senate may lose its one seat majority; everything that moves will have to be bipartisan, which is hard to strategize.
- Bob recalled when that happened in MI, asked about challenges. Jinny said some of the federal rhetoric has found its way to state level; tracking some bills of concern, pulling back DEI, social determinants of health, and health related social needs. Basic health plan was expanded to cover non-residents, but this may go away. Work with paid family leave may stop. Concern about Medicaid every day.
- Kyle: some of this is similar in KS. Continued commitment to CCBHC. Workforce initiatives including universities, state Medicaid agency, providers. Spending on telehealth was too high. Not the same kind of election cycle in KS, lots of situations where 2-3k votes decided an election. Two years from now could be different so prepare for all scenarios and know who to call.
- Adam: trying to establish a separate Bureau of Labor Statistics (BLS) classification to build the Direct Support Professional (DSP) workforce. Ohio was operating off of a

very old rates structure. Lack of funding created multiple challenges, and the pandemic prolonged the rates restructuring because services were reshuffled, but it made the workforce shortage even worse. Collaboration of providers and family groups to make the case to legislators through compelling testimony. Moved from \$13.75 an hour to \$16 through prior successful advocacy, now to \$19 in the second year. This is not sustainable because other industries with lower risk still pay better. We need to tie incremental increases to costs of doing business so we don't have to keep doing this every few years, while political fortunes change. Property taxes pay a significant portion of Medicaid services, but prop taxes are quite high in Ohio due to funding so much of local government. Taxes go up significantly and raise some ire, so increases in these rates have to come from the state's general revenue fund. Many more children are coming into early intervention, and there is also a multisystem youth surge. All of the agencies had a portion of children and youth services and were siloed, so the governor established a commission. Need to find a different way to get services to children who don't have I/DD but are labeled that way just so they can have some resources. Gov proposed \$30m for children with BH challenges.

- David: since 2011, VA in a DOJ settlement related to IDD and can exit now. Prompted considerable investment in DD services. The closing of all but one training centers, with major increase in waiver services. State is funding the last 3000 slots over the next two years, for the highest need folks, but the workforce can't match the needs. VA has one state agency for IDD and all BH, has had trouble getting those waiver slots out timely, so there's a lot of pressure from DOJ. That gets transferred to the CSBs. The governor did make investments in BH as promised. The state dedicated land to building one of these centers, but we don't have the land yet. CCBHC has not been done in VA as in MN. Gubernatorial election this year. Ready to propose a new model to each of the candidates as they're identified. The private sector is complicating crisis response; some areas have atrocious rates and response times because people are jamming up the lines on purpose. Crucial to the public BH system. Good things are happening but within a difficult context.

### ***“Issues Affecting Access to Care”***

*Ensuring access to behavioral health and I/DD services is critical to strengthening the health of our communities... there are many factors affecting the ability to connect individuals to care...*

**Jinny Palin** introduced the panel and moderated.

**Angela Kimball**, Chief Advocacy Officer of “inseparable”.

- Four priority areas (youth MH, access to care, crisis response, MH workforce).
- In 20 states, passed 57 pieces of legislation (8 of these were in IL.)
- Engage with state lobbyists on 3 main strategies.  
Diversify funding streams: significant deficits in many states, esp blue ones (e.g., loss of ARPA funds), potential loss of Medicaid; state efforts like school Medicaid expansion, which half of states have already done, and crisis telecom surcharge.

Expand the behavioral health workforce: with severe workforce shortages, states can enhance reimbursement rates, loan repayment, reform licensure and credentialing (e.g., UT SB26, 2024).

Improve health plan coverage: rules can limit access; states can improve patient protections in statutes (e.g., IL HB5395, 2024, CO HB1002, 2025), ‘no diagnosis’ for Medicaid mental health services (e.g., CO HB174, 2023).

**Sarah Hohman**, Director of Government Affairs, National Association of Rural Health Clinics.

- Advocacy and education are primary goals.
- Rural Health Clinics (a CMS designation) have enhanced Medicaid and Medicare reimbursement, which helps to attract and retain professionals and stay in business.
- 5600 RHCs in 47 states, primary and specialty care, serving 62% of rural US citizens.
- Only up to 49% of an RHC’s services can be mental/behavioral health, often related to how coded, so they are working to reintroduce the 118<sup>th</sup> congress RHC Burden Reduction Act to eliminate the barrier of 1977 language (IMD). Some pushback from CCBHC advocates, but many areas served by RHCs would not be able to support CCBHC anyway. Seeking a clean strike of that provision.
- Rely on reimbursement as there has not been a grant program solely; it’s hard to write competitive grants with low staffing rates. A workforce bill solely for RHCs would provide startup funds to cover initial salary as a new provider builds up their panel, then sustainable through reimbursement.
- Big challenge is no reimbursement for services to the uninsured.

**Michele Gazda**, Associate Director of Health Policy, Bipartisan Policy Center.

- Policy areas: health care delivery system redesign; safe and secure social media use; and prevention, early identification, and intervention.
- Had in mind some conservative approaches to fiscal responsibility. For redesign, strengthening and growing the BH workforce, enforce screening and treatment requirements, integrate BH and primary care in pediatric settings, improve youth services (high acuity BH needs and multisystem involvement), strengthen crisis stabilization services for youth.
- Telehealth seen as a major part of the solution. [mgazda@bipartisanpolicy.org](mailto:mgazda@bipartisanpolicy.org)

**Marianne Gibson**, Program Director on Health Team, National Governors Association (NGA).

- History of the NGA. Represent all 55 state and territory governors. Proud of our bipartisanship. NGA Center for Best Practices. Numerous areas, policy briefs by subject matter experts. In person convenings, webinars, TA (9-12 months).
- Next Generation Knowledge Exchange Network States and Territories (includes IL) with TA topic areas: healthcare workforce; workforce supply data; scholarship and loan repayment; apprenticeships; childcare, housing, and other non-monetary subsidies; workforce wellness; scope of practice. Can be done by aligning state agency strategic plans with a singular state strategic plan for workforce, partnering with private sector, issuing EOs, looking at regulatory and rule changes. Another policy academy has 3 of 4 states/territories working on BH workforce; charters with roles/responsibilities; translating policy to non-policy folks.

- Discussion of the new challenges, hyperpartisan environment, threats to Medicaid, harsh fiscal realities, difficulty reaching the right person. Every district is impacted by family safety. Waiting for reauthorization of some popular bipartisan programs. Ensuring access to physical and behavioral healthcare are among top five bipartisan priorities. States will have hard decisions to make regarding access. Be ready to make substantive changes when federal circumstances change. There is so much energy to do the right thing to improve access, on both sides of the aisle. Resilience is a focus even where ‘social emotional’ is not spoken of.
- Shared values behind closed doors. Always opportunities for collaboration.

### ***Special Lunchtime Presentation***

**Anita Everette**, Director Center for MH Services (CMHS), SAMHSA.

- Overview of SAMHSA. CCBHC Expansion; Select CMHS Crisis Activities and Services; Minority Serving Institutions (MSI) training.
- Review of 9 core services of CCBHCs: crisis, outpatient MH and SUD, person and family centered treatment planning, screening/diagnosis/risk assessment, psychiatric rehab services, outpatient primary care screening and monitoring, targeted case management, peer and family support and counselor services, and community based MH care for veterans.
- Doing CCBHCs for over ten years, adding 10 new demonstration states each year. Lots of complexity regarding the types of funding they receive. Currently about 500 across 46 states. 18 states are participating in Section 223 CCBHC Medicaid demonstration (this includes IL,) but most demonstration states are not statewide and are instead adding sites over time. SAMHSA grants are for startups or performance improvement. Positive broad outcomes are social connectedness, attending school/employed/retired, and positive functioning in everyday life.
- Three core components of crisis services: someone to contact (988 suicide and crisis lifeline), someone to respond (mobile crisis teams), and a safe place for help (crisis stabilization). Regional Crisis Contact Centers funded through MH block grants, CCBHC expansion, and 988 grants. Mobile Crisis Teams (MCTs) through MHBG, CCBHC expansion, and community crisis response partnership program. Crisis Receiving and Stabilization Facilities through MHBG and CCBHC expansion.
- Planned Crisis Services: 14 new call centers, 170 MCTs, 27 Children’s MCTs, more.
- Community Crisis Response Partnerships Overview. Through 25 grant recipients, 29k individuals were screened for suicide ideation, 13k referred to crisis or other mental health services, and 4700 were diverted from law enforcement.
- SAMSHA’s SMI Training and TA Center. Working on access to Clozaril for those with schizophrenia not responding well to other meds due to side effects. Physicians may get TA from experts, usually within a day.
- More programs, treatment and recovery support. Homelessness programs and resources. PATH, TIEH, and SOAR.

### ***“Crisis Response Presentation Panel #1: User Experiences, Crisis Lines, and System Transformation”***

*The crisis continuum of someone to contact, someone to respond,, and a safe place to go requires coordination between behavioral health care, emergency services, law enforcement,*

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*and other sectors... 988 user experiences, coordination of pre-existing local crisis lines, and efforts to transform the system.*

**Jonathan Purtle**, New York University School of Global Public Health.

- Study #1 was on how 988 is financed.  
Ten states have fees. Per capita (5 states) average \$1.80. Assess and compare perceptions of the extent to which 5 domains of financing factors: have positively influenced 988 implementation; and are important to moving forward. Showed big differences between how these are perceived.
- Study #2 was on public preferences for 988 and other crisis services.  
Nationally representative survey of (5k) adults. How likely to use 988, another crisis line, an MH professional, a friend or family member, or someone in their religious network. Looked at demographic factors associated with preferences.  
Found five distinct groups:  
Seek Help Anywhere (23% of total) – likely to use all sources. Black, non-Hispanic.  
Seek Help Nowhere (21% of total) – none of them would use 988, strong feelings about not reaching out to any of the sources. No college education, male.  
Definitely not 988 Yes Friends and Family Distressed (13% of total)– 61% would use friend, none 988, serious distress in last 30 days.  
Relatively Indifferent and Not Distressed (17% of total) - not young adults, Black, non-Hispanic.  
Seek Help Most Places but Not Religious Network (26% of total).
- <https://onlinelibrary.wiley.com/doi/10.1002/wps.21285>

**Cherryl Ramirez**, OR on Evolution of the Oregon Crisis System.

- All three legs of the crisis continuum. Service delivery structure of Community Mental Health Programs (CMHP.)
- Evolution of mobile crisis response in OR, funded by a patchwork. The two 988 call centers, at \$39.5m, are funded with a special tax and through Medicaid.
- Still have crisis lines, for which call volume has not decreased since adding 988; it actually increased 10% total statewide. In the Portland area, calls increased by 16%. Higher mobile crisis response rate to these calls than to 988, so there's still a need to keep and fund the county crisis lines until 988 is fully accepted and utilized.
- Status of Mobile Crisis and Ongoing Challenges: new requirements following the Crisis Now model (Jan 2023); transitioning in 2023 and 2024 due to workforce retention challenges; goal to be eligible for higher federal match, but 40% of crisis services are funded by Medicaid. Grassroots mobile crisis worker training academy!
- Current Mobile Crisis Coverage: some areas have the 2-person awake coverage 24/7.
- Challenges to expansion: reporting requirements; 2 person team (one a QMHP) 24/7.
- Ensure continuation of county/CMHP crisis line funding in contract with CMHPs, funding the gap of the true cost of crisis services, which is about \$59m /2 years.

**Jennifer Battle**, VP Community Access and Engagement, The Harris Center for MH and IDD.

- Overview of The Harris Center and reach of services: 792k adult MH services, 315k IDD services, 191k child MH services, etc.

- Local Authority Service Areas. Texas has 254 counties, with 39 local BH authorities operating local crisis hotlines and mobile crisis outreach teams. Four local authorities answer 988 calls throughout the state; an additional center is statewide backup.
- The Harris Center Crisis Continuum components: Neuropsychiatric Center, Mobile Crisis Outreach Team, Crisis Intervention Response Team, Homeless Outreach Team, Chronic Consumer Stabilization Initiative, Clinician and Officer Remote Evaluation, Rapid Response Pilot, ARPA Subrecipient Rapid Response, etc.

**Mark Hensen**, Director of Federal Advocacy and Government Affairs for the Trevor Project.

- Bipartisan support for MH has grown, less agreement on details. Showing data and telling the stories does make a difference.
- How crisis work with LGBTQ+ youth has gone. Ideas and strategies to include high risk populations and build trust. Trevor has 24/7 support via call, text, and chat, resolved over 500k contacts last year. Demand grows. Prevention includes peer-to-peer counseling, training for institutions, and research.
- 4x as likely to consider suicide. 12% attempted. 84% of youth surveyed want to access MH care but over half were unable, due to various barriers. 10% of US identifies as LGBTQ+, and a higher percentage of young people.
- Trevor has often been the option of last resort, sometimes the entry point to all MH services. Goal is a well-resourced crisis line with well-trained staff. Implement practices to eliminate barriers to care (including building trust.) Support further developing the continuum of care.
- In two years, 988 served over 14m contacts; referrals to veterans' crisis and LGBTQI crisis care. Nonpartisan, apolitical support for building out the continuum of care. Many don't believe the MH system can offer the care they need. Concerns are similar to other high-risk communities, e.g., cost, fear of reaching out, fear of sharing concerns, fear someone would call police or institutionalize them, fear of being outed.
- Trevor has worked on reducing stigma and incorporated people with lived experience. Continuous quality improvement. Need knowledge of high-risk populations across the system because another reason people don't access care is having ONE bad experience when they did reach out. <https://www.thetrevorproject.org/>

**John Palmieri**, Acting Director of 988 & BH Crisis Coordinating Office, SAMHSA.

- Lead federal org for 988 & BH crisis services transformation. Partners with the FCC and US Dept of Veterans Affairs.
- Data collection, quality standards, oversight and funding for 988, 988 Lifeline a network of over 200 local and state funded crisis centers.
- Lots of priorities, trying to focus on what will be most impactful: localized routing for calls and eventually text; continued capacity building and response rates; national evaluation plan; workforce burnout; post 988 contact connectivity and follow up services; increase 988 awareness, familiarity and trust; and grant programs.

**Panel Q&A:**

*How can we use technology and what are limitations?*

- Cheryl: better connection of electronic health records to reduce duplication of data entry in multiple systems; eliminating multiple reporting; tech doesn't solve all the problems as this is best with human contact.
- Mark: must make it easier for the caller, who may struggle to decide to reach out for help; concerns about privacy higher with high-risk pops trying to reach the most tailored services available.
- Jennifer: quality assurance reviews on 3% of incoming calls, a huge number for a center with no additional resources to do that, so using limited AI to cut down on manual staff time; public safety designation for 988 centers (like 911) would help with more resources; tech is a big reason people quit; second big reason is abusive callers and no protection for team.

*What gives us hope?*

988 growth since its implementation.

### ***“Crisis Response Presentation Panel #2: Other Crisis Lines, Rural Crisis, and Crisis Stabilization”***

*... coordination of crisis lines, approaches to rural crisis response, crisis stabilization.*

**Rene Hurtado**, Emergence Health, TX. Moderated and introduced the panel.

**Travis Atkinson**, TBD Solutions, MI.

- Danger of overserving.
- Produced National Crisis Residential Funding Survey and Crisis Residential Best Practices Handbook and two surveys about how crisis providers were experiencing the pandemic: 1/3 were seeing increase, 1/3 same, and 1/3 seeing decrease.
- 3 Policy Considerations:  
Disparate service offerings lead to disparate outcomes: crisis stabilization centers all defined differently; compare San Diego County, smaller but with lots of crisis beds, to Cook County, which has zero crisis beds; substantial savings through crisis care, saving Austin-Travis County health care system \$2.8m annually; people in recovery really can be helpful.  
True alternatives must look and function differently: lower hospitalization rate, etc. System funding must be reliable with accountability for provider performance: show cost savings in a fiscally conservative environment; reimagine payments for some crisis services from fee for service to risk sharing/value-based models.

**Chip Johnston**, MI.

- Following a community tragedy, a proposed solution was collaboration of county-based community mental health provider and sheriff's office. Engaged Ferris State University researcher to study the results of these efforts.
- Demographics of 32 participants over 10 months: mean age was 36.35; 27 adults and 5 juveniles; 19 male, 12 female, 1 other; 16 white, 14 Black, 2 other.
- Call Occurrence data confirmed 'blue flu' with majority of calls in January and March, starts in September, and most calls on the weekdays.
- Call disposition: 11 suicidal, 8 suicidal and BH, 5 possible psychosis and BH, 1 SUD, 1 MH, 2 welfare check. Instead of jail they went to ED, ED and psych, etc.

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- Stopped taking data in October due to end of fiscal year; came to talk with Sheriff and County commissioners, with 911 in the room, who said they seemed to be missing many calls and added an option in their data system to get a true idea.
- Immediate access to services; increased community goodwill and support for county-wide network; bridged cultures and increased trust between MH, law enforcement, and first responders; partners will have final report in October.

**Ted Lutterman**, National Association of State Mental Health Program Directors (NASMHPD) Research Institute.

- Work with state depts of MH and SUD. Looking for where they're at with crisis continuum and where TA is needed. Reports on website, state level data for all 50, on crisis services continuum, crisis contact centers, and mobile crisis teams.
- 202 "988" and 425 other contact centers. 1820 mobile crisis teams. 576 less-than-24-hour crisis stabilization facilities, and 693 crisis residential programs.
- Expenditures Supporting BH Crisis Services: because crisis services are provided without regard to pay source, the public system has been covering where people have private insurance; some states are now seeking parity on this, so private insurance will cover crisis services in all states.
- Many states are putting their data on public dashboards so you can see what is happening across the system; collecting measures of the impact of crisis services, mostly of use of services, as it is hard to assess suicides averted. <https://nri-inc.org>

**Billina Shaw**, Senior Medical Advisor, Center for MH Services, SAMHSA.

- Leverage existing resources to inform the work: environmental scans, state-level crisis service definitions and standards, peer reviewed literature, best and promising practices, elevating exemplars.
- The right level at the right time, in that not everyone needs to go into a locked unit. Evidence-informed. Developmentally appropriate. Recovery oriented. Systems based. Person centered. Standardization and Sustainability are the two main frames for this.
- Advocates in the peer community were clear that 'warm line' was a peer term and should be honored, so other emotional support lines will be differentiated.
- Community outreach teams are not crisis but postvention. Emergency, crisis, and crisis related services; with emergency the high intensity (emtala-like), then referral based. 2025 National Guidelines.
- Rural communities have had a hard time implementing the "crisisnow" model, so flexibility is needed in system development. (<https://crisisnow.com/>)
- Core principles: administrative structure, oversight, and policy; communication and community engagement; BH crisis care; mobile crisis toolkit is granular, addressing specific concerns, in 13 chapters. 2020 guidelines didn't have much on 'how to'.

**Panel Q&A:**

*What level of coordination needs to happen, given this tangled set of lines?*

- Dr. Shaw: other data use agreements, connecting EHRs, connectivity, data matching.
- Ted: no wrong door, easier to get to the right service, make sure the response is not an untrained officer with a gun.

- Chip: UP was an early test site, a huge place with 300k people with one area code, so now the call is switched in to the local center.

*Other thoughts or words of wisdom on rural response?*

- Ted: outside of Tulsa they couldn't get teams staffed so they used iPads, programmed to connect to grand lake crisis teams, which reduced use of hospital and jail so now all law enforcement vehicles have these iPads and connect people via facetime to crisis workers.
- Travis: Ohio contracts for crisis services, need collab relationships for common ground/values and not being afraid to use data to manage a crisis benefit; we should not use tactics of power with our partners, esp when we are being challenged.
- Dr. Shaw: in rural communities, the relational part can be overshadowed by MOUs.
- Chip: hard to get some partners to sign MOUs; many places had dial up until recently.

***“Closing Keynote – SAMHSA: Advancing Behavioral Health”***

**Tom Coderre**, Deputy Assistant Secretary, SAMHSA

- Make America Healthy Again. Overview of SAMHSA. MH and SU Policies, - Programs, and Supports. Workforce. Resources.
- MAHA Agenda: gain understanding, investigate, and address root causes of US health crisis; lower chronic disease rates; end childhood chronic disease; address rising MH disorders, obesity, diabetes, and other chronic diseases.
- SAMHSA will support the executive agenda, providing relevant resources.
- Decline in overdose deaths, very promising, attributed to the work of counties and states to address. Partners at DEA also note less potent substances.
- Multifront Advances, including Naloxone Saturation, involving 26 states, DC, and Puerto Rico, through a policy academy, collaboration with universities, websites with naloxone locators, and awareness campaigns. 41% increase in naloxone kits.
- Ongoing implementation of 42 CFR Part 8; historic changes, videos on SAMHSA's youtube, treating Opioid Use Disorder (OUD) as a chronic health disease, promoting recovery, strengthening the workforce.
- Recently published briefs and guidelines: mobile medication units and health clinics, xylazine and drug mixtures, OUD in older adults, OUD in Pregnant and Parenting women, meds for OUD.
- Advancing Evidence-based Prevention: policy academy, SDOH toolkit, incorporate young people and their families to inform the work, e.g., the FentAlert Challenge.
- Updates on 988 and crisis care system.
- Commitment to addressing SMI and SUD.
- Children's MH Initiative: Systems of Care - integrating all areas, even DD, and expanding access to care.
- Enhancing access to MH services through CCBHC, the fastest growing program; 2024 data show improvements in three positive outcomes and reductions in five negative outcomes (decrease homeless, incarceration, emergency room visits, etc.)
- Addressing Kids Online Health and Safety: respond to rising youth anxiety; resources are family media plans, conversation cards, strategies for parents, online portal for TA from healthcare experts.
- Expanding school-based MH supports and services; Project AWARE and Trauma-informed Support Services (TISS), with 5k school staff trained in TI Care.

- Workforce – <https://samhsa.gov/technical-assistance> Centers of Excellence and Training; BH Workforce Career Navigator (for aspiring BH professionals, requirements per state). [www.samhsa.gov/988toolkit](http://www.samhsa.gov/988toolkit) and [www.samhsa.gov/grants](http://www.samhsa.gov/grants)

### **Questions:**

*Relationship between SAMHSA and CMS?*

- Important to protect BH initiatives from any cuts or changes in Medicaid.

*IMD rule changes?*

- Defer to Congress, but this would be game-changing for BH.

*What gives you hope?*

As a person in recovery, having rebuilt my life over the last 21 years with the sense of community allows me to have a lot of hope anyway. Through working at SAMHSA and in government, I know that the winds of change blow in and out, but behavioral health issues are extremely important regardless of party. We may have to do this work with fewer people, but hopefully grant funding will continue to flow to communities. Going backwards is not an option.

### **“Legislative Panel”**

*Congressional leaders are instrumental in this time of transformation for behavioral health and I/DD. Lead staffers focused on behavioral health and I/DD. Some who were invited chose not to join us, and those who joined us asked that the content of the discussion remain private. Many items discussed have been addressed in other conference session notes. Both staffers were very optimistic about the future despite immense challenges in this moment.*

### **“Health Policy Insiders Perspective”**

*With a new Congress and Administration, this year is anticipated to be a dynamic time for health policy... perspectives from experts in mental health, substance use, and I/DD federal advocacy.*

**Jonah** introduced the panel and posed questions.

**Andrew Kesser** has worked on SUD policy for 20 years; NIH research, clinical, SAMHSA.

**Al Guida** has clients in DC including Netsmart and crisis textline.

- Can’t imagine the chaos we’re all dealing with; will clarify the January Office of Management and Budget (OMB) memorandum and other budget issues.

**Dara Lieberman**, Director of Government Relations at Trust for America’s Health.

- Public health policy and research and advocacy, to strengthen the public health system, population level, equity as a foundation.
- Talk to legislators to keep people healthy in the first place. <https://www.tfah.org/>

**Alyce Aguilar**, Senior Director of Federal Relations at ANCOR

- Primarily HCBS providers, to sustain the services we have in communities, already fragile system. Ensuring accessibility, then strengthening the service sector. Serves a broad spectrum of members. <https://www.ancor.org/>

### **Panel Q&A:**

NACO and NACBHDD 2025 Legislative and Policy Conference Session Notes

*Difference between appropriations and reconciliations?*

- January OMB memo froze \$3 trillion in federal spending (FY24 dollars), shut down Medicaid portals in many states. Largely reversed through federal court injunction. There is an FY25 continuing resolution (at FY24 levels) which ends March 14. Without it there will likely be govt shutdown.
- Then reconciliation process for the year moving forward, also covers next ten years of federal spending for programs such as Medicaid, as there are only six operations under Health Committee (NIH and CDC included.) House and Senate still have to negotiate because they didn't pass the same reconciliation bills, most spending is Medicaid; likely April before reconciliation process gets underway.
- Traffic jam now, since they will have to do FY26 by September.

*Priorities under mandatory or discretionary funding?*

- ANCOR is very concerned about this budget reconciliation process and Medicaid. The House reconciliation instructs the House Education and Commerce committee to cut from it deeply, but new house members don't know about these programs and services, so our focus is on educating them. Would love additional focus on workforce so that HCBS services are available to people; there had been bipartisan support for a standard classification for DSPs.
- For public health, similar framing, offensive strategy, but given the unusual and huge threat, we have to focus on education, report on vision for strengthening public health (support for CDC, which includes behavioral health) at the population level, and prevention. Focus on how cutting this federal workforce impacts your state.
- This priority is not as bipartisan when it comes to spending. DOGE looks like a reality, so we need to show how these programs work. We want increased workforce and recovery community and care but are not optimistic about increases.
- Providers are committed to whole person care, so cutting other programs does not make sense. Despite dramatic decreases in overdose deaths, the narrative on public health approach to SUD is being undone by new priorities and rhetoric about borders (which were not changed, proving that the prevention approach is what worked.)

*Prevention funding?*

- Budget reconciliation is currently used to extend tax cuts with a simple majority. \$2b of CDC funding is in prevention (total budget around \$9b), so this is a big hole for the appropriations committee to fill, of discretionary programs.

*Impacts of federal lay-offs?*

- SAMHSA employs 600, lost 95 probationary staff, resulting in closure of 3 regional offices off the top. Memoranda indicate planned reductions in 50-70% range; their budget is block grants for MH and opioid, flowing to the states, plus about 40 line items. Not sure what will happen even where there is a powerful lobby such as CDC has; CDC currently intervening in measles outbreak in TX, doing so on their own.

**Grace Pennix** described communication and committee efforts.

**Jonah** offered a certificate of appreciation to **Kyle Kessler**, Past Chair.

***“Partners in Progress: Federal Partners”***

NACO and NACBHDD 2025 Legislative and Policy Conference Session Notes

*Impactful policy hinges on cross-sector relationships, especially those spanning between local and federal authorities. By understanding federal efforts related to behavioral health and I/DD policy, local providers can better utilize available resources.*

**Jonah** introduced the topic and panelists.

**Mary Sowers**, Executive Director, National Association of State Director of DD Services.

- Members are state DD directors. Medicaid challenges and opportunities. NASDDDS Medicaid primer reinforces the message that IDD systems are Medicaid systems, with HCBS the largest share of services for them. Current threat has implications for IDD.
- Overview of the budget reconciliation process, current state of play; senate budget resolution with reconciliation versus house budget resolution with the \$880m cuts instruction which put Medicaid on the table.
- Policy and practices that impede progress today are based on the myth that people with IDD can't have MH conditions, experience trauma, or benefit from treatment. Led to exclusions from rehabilitative benefits, coverage and medical necessity policies, clinical availability, and providers unwilling to offer treatment. While accommodation may be needed, providers don't need to learn something new.
- Removing siloed support is urgent and essential. Too many people fall through cracks between systems, so NASDDDS is working with other associations to bring together.
- Effective Quality Supports, from Policy to Practice, to reduce law enforcement and emergency room contacts, case of eventual medical assessment revealing migraines.
- The Link Center Partner Organizations, funded by Administration for Community Living (ACL), includes NASDDDS, NADD, NASMHPD, NASHIA, with advocacy groups and collaborators. <https://acl.gov/TheLinkCenter>
- Overview of possible Medicaid changes. As lawmakers consider Medicaid reforms, state financing, federal financing, other policy changes. <https://www.nasddds.org/>

**Kirsten Beronio**, Senior Advisor, National Association of State Mental Health Directors.

- Primarily technical assistance. Work with SAMHSA and CMS to promote the priorities and interests of state MH directors. Share funding opportunities, peer to peer learning, policy papers and toolkits, webinars, and learning communities.
- High priority topics: cross-cutting focus on Medicaid; 988 and Crisis Response; CCBHC; promoting evidence-based practices (e.g., coordinated specialty care); peer support and recovery (questions about supervision requirements have been left to states to decide); Home and Community-Based Services (partnering with NASDDDS and NASHIA on this, esp through the Link Center); CCBHC expansion; Workforce Solutions Jam and related efforts. <https://nasmhpd.org/>

**Rob Morrison**, Executive Director, National Association of State Alcohol and Drug Agency Directors (NASADAD.)

- Came to DC in 1993. In addition to state directors, NASADAD works with affinity partners from the prevention and treatment networks, women's services, etc. Already lots of talk about potential changes, so we need to continue being clear about opioid and other SUD and the positive impacts of existing programs.
- Primary prevention for SUD funding has come from block grants but not much \$.

NACO and NACBHDD 2025 Legislative and Policy Conference Session Notes

- Distinct changes in Medicaid covering treatment will have a domino effect across the continuum. Those of us working prior to the Affordable Care Act (ACA) will remember some of the hardships we might expect to see come around again.
- Still have work to do on messaging on the opportunities crisis services present related to SUD; we need to be more specific now. The underlying bill for 988 didn't mention SUD at all, but after it passed, people talked about needing crisis services for SUD too, so we're a bit behind; need expertise in mobile crisis response.
- Also on the criminal justice and reentry side. Workforce problems in this area too.
- For maternal OUD, there is continued lack of family-centered, long-term services, determined by a person's condition. Limits such as 30 days are arbitrary and not appropriate, leaving us to fill the gaps. <https://nasadad.org/>

### **Discussion:**

- Turnover and wage issues in IDD, so looking for other ways to retain staff, such as creative benefits. Clinical shortage also impacts IDD. Workforce a challenge across the board; focus on integration and expanding the pool of workers who can help with conditions (beyond physicians, psychiatrists, counselors). Need to understand the SUD prevention workforce capacity and gaps. Looking at technology solutions.

*Will your associations have to merge, including the association for those aging with physical disabilities and other related groups, due to funding losses?*

- All will be involved in upcoming symposium, esp with their increasing partnership.

*How can we reduce the administrative burden on providers, which is another driver of high staff turnover, as states are very risk-averse?*

- It is about more than the reimbursement rates and inflexible service categories; 1115s can also address some of the burden, at least offloading from practitioners, a longer term project. Choosing between recovery services and medication administration seems like a mistake. Traditional clinical approach is not easily applied to MH and SUD. In opioid crisis, other providers may feel overlooked, and muddling the prevention issues, which should be seen across the language; demystify some of the language of primary prevention.

*What gives you hope?*

- The broad interest of many people and groups hasn't changed; momentum should continue. Young people are very engaged and open on MH and SUD topics, way more aware than in the past. Creating solutions as discussed.
- In terms of policy, hopeful that these issues continue to be bipartisan, though it may be hard right now to see how that will continue.
- People with IDD are not monolithic, and our systems seem finally aligned to acknowledge the breadth.

**Jonah** reviewed our mission, vision, and values, all of which we touched on today.



## **DECISION MEMORANDUM**

DATE: March 19, 2025  
TO: Champaign County Developmental Disabilities Board (CCDDB)  
FROM: Kim Bowdry and Leon Bryson, Associate Directors, and  
Lynn Canfield, Executive Director  
SUBJECT: Evaluation Capacity Building Years Three and Four

### **Background and Purpose:**

When a seven-year “Evaluation Capacity Building” project ended in summer of 2022, agency partners, along with members and staff of the CCDDB and Champaign County Mental Health Board (CCMHB), expressed interest in a subsequent project to enhance agency capacity for collecting and reporting data on outcomes, which helps the Boards in their planning and communication with the public.

A Request for Proposals for Evaluation Capacity Building Project was conducted, resulting in a contract for a new evaluation project. RFP2022-10 is posted at [cmhddbrds.org](http://cmhddbrds.org) and <https://www.co.champaign.il.us/bids>. Meeting recordings and minutes can be viewed at <https://www.co.champaign.il.us/mhbddb/MeetingInfo.php>.

Family Resiliency Center’s extensive proposal resulted in a two-year contract which ends April 30, 2025. This memorandum offers an update on evaluation project activities, with a suggested action to continue the project for another two years.

### **Overview of FRC Evaluation Team Activities – Years 1 and 2:**

The evaluation team conducted assessments to determine approaches most helpful to the Boards and funded agencies. A report on the results of Group

Level Assessment was presented to each board at January 2024 meetings. This can be reviewed within the [CCMHB meeting packet, pages 103-117](#).

An executive summary of the first-year report was presented to each Board in May 2024 and in June, the full report, which can be reviewed within the [CCMHB meeting packet, pages 146-210](#).

The **needs assessment** consisted of a group level assessment event, 2 surveys, 13 interviews and focus groups, and the review of 64 agency reports. In total, perspectives of 76 agency staff, agency leaders, and evaluators informed the findings and direction of evaluation activities.

The evaluation team provided evaluation **technical assistance and capacity building** to three programs in Years 1 and 2 and added a fourth program in Year 2. This has led to the development of surveys based on published literature and participant feedback, data collection systems that provide greater efficiency and organization for tracking process data and outcome data, and the development of data analysis skills. The team has informally met, as needed, with other programs and agencies to support evaluation capacity and learn about the needs of local agencies.

A **working group** of 3-6 agency representatives was developed in Year 1 and continues to meet every other week, biweekly in Year 2. Working group participants discuss their evaluation experiences and provide focus and content input on training, microlearning, and other activities developed by the evaluation team to increase relevance to agencies.

In Fall 2024, the evaluation team hosted a **workshop** on identifying program outcomes and using the measures repository/bank which had been created by the prior evaluation team and updated by the current team. Planning for future trainings and microlearnings is underway.

Microlearning videos on the following topics are [posted here](#) (<https://www.familyresiliency.illinois.edu/resources/microlearning-videos>.)

- Logic Model – Inputs

- Logic Model – Outputs

- Logic Model – Outcomes

- Logic Model – An Example of Creating a Logic Model from Inputs through Outcomes

- How to Avoid Overpromising & Underdelivering

## **Evaluation Team Activities – Years 3 and 4:**

*Attached* is a proposed Two-Year renewal which includes budget details, personnel responsibilities and roles, and scope of work similar to the original comprehensive proposal but updated using input from participants and CCDDDB-CCMHB staff and board members.

In late January to mid-February, we used a brief, fully optional and anonymous survey to understand agency experiences with this project.

Responses included expressions of interest in learning more about how to organize data, use a logic model, receive technical assistance, and define meaningful and measurable outcomes for special populations (such as adults with developmental disabilities) or for unique services (such as peer support and mentoring.)

From the survey responses, we also abstracted two concerns that are outside the control of the Evaluation Capacity Building project team and that we wish to address here:

1. *Uncertainty about how programs are selected for intensive support.*

The Evaluation team has not made those decisions. Instead, Board staff have identified candidates through the review of funding applications and included these in our recommendations for funding awards. During the contracting process, Board staff and agency staff have determined the feasibility.

2. *Guidance on what are deemed appropriate outcome measures and effective methods for measuring them, to improve grant applications and program structures.*

When Board staff review applications, we critique the proposed outcomes to point out where revisions should be made IF a contract is awarded rather than used as a factor in determining whether to award one. This issue was also raised last year, but we are committed to keeping application and allocation decision processes fair and open.

Because the intent is to improve communication of a program's impact on the people it serves, outcome measures and tools will be of value to many service providers, regardless of funding source. The Evaluation team makes their trainings and toolkits public so that any organization interested in using these strategies will have access to them, and CCDDDB-CCMHB staff link these resources on our application site's public page and within related public documents. With this survey feedback, we will continue access to all resources developed through the current and any future similar contract.

### **Budget Impact:**

The current contract is for a twenty-four-month period, from May 1 to April 30. The first full year of the contract had a cost of \$125,003 and the second year, \$128,765, for a total cost of \$253,768. Per RFP2022-010, the parties have an option to renew the contract for another two years. If the parties exercise this option and continue with similar annual cost increases, the third year would cost **\$133,826** and the fourth **\$137,860**, for a total of **\$271,686**.

With a start date of May 1, and using the administrative cost split defined in the Intergovernmental Agreement between the CCDDDB and CCMHB, this results in the following costs per fiscal year per Board:

- The remaining obligation for the second year of the current contract, for January through April 2025, is \$42,925.  
Eight payments on a third-year contract, for May through December 2025, add \$89,216.
- The **2025 total** of \$132,141 is split, \$55,697 DDB and \$76,444 MHB.
  
- Four payments on the third year of the contract, for January through April 2026, are \$44,610.  
Eight payments on the fourth year, for May through December 2026, add \$91,904.
- The **2026 total** of \$136,514 is split, \$57,541 DDB and \$78,973 MHB.
  
- The remaining obligation for the final year of the contract, for January through April 2027, is \$45,956.
- The **2027 total** of \$45,956 is split, \$19,370 DDB and \$26,586 MHB.

**Decision Section:**

Motion to authorize the Executive Director to enter into a twenty-four month extension to the contract with the Family Resiliency Center for the support as proposed, with a start date of May 1, 2025, end date of April 30, 2027, and total cost of \$271,686, pending approval by the CCMHB.

- Approved
- Denied
- Modified
- Additional Information Needed

Champaign County Developmental Disabilities & Champaign County Mental Health Boards

Evaluation Capacity Building Project

Two-Year Renewal

05/01/2025-04/30/2027

**Budget Justification**

The Family Resiliency Center (FRC) at the University of Illinois Urbana-Champaign submits this budget justification for a two-year continuation of the evaluation capacity building project. FRC will continue evaluation technical assistance and training activities and deliverables from May 1, 2025 – April 30, 2027. This budget reflects approximately a 3% increase per year, consistent with the previous two years. This accounts for changes in fringe rates and cost of living adjustments.

**Budget**

We estimate the cost of the continued capacity building activities at **\$133,826 in year 3 and \$137,860 in year 4** (Table 1) for a **total of \$271,686**. These costs are inclusive of salaries (\$80,530 in year 3; \$82,947 in year 4), fringe (\$29,492 in year 3; \$30,376 in year 4), and materials and supplies (\$1,500 in year 3; \$1,560 in year 4) as well as indirect costs (\$22,304 in year 3 and \$22,977 in year 4) calculated at 20% per the Champaign County Developmental Disabilities Board Requirements and Guidelines for Allocation of Funds: [https://www.co.champaign.il.us/mhbddb/PDFS/DDB\\_Funding\\_Guidelines\\_122021\\_FINAL.pdf](https://www.co.champaign.il.us/mhbddb/PDFS/DDB_Funding_Guidelines_122021_FINAL.pdf)

Fringe benefits applied have been calculated by a method approved by the Federal Government. Fringe benefits are charged at a rate of 45.86% on senior personnel salary. Fringe benefits for graduate research assistant salaries are charged at a rate of 10.35%. Hourly salary is calculated at 7.66% fringe, hourly student benefits are calculated at a rate of .01%.

**Table 1.** Budget by Category and Year

<b>Cost Category</b>	<b>Year 3</b>	<b>Year 4</b>
Salary	\$ 80,530	\$ 82,947
Fringe	\$ 29,492	\$ 30,376
Materials/ Supplies	\$ 300	\$ 360
Honoraria	\$ 1,200	\$ 1,200
Indirect Costs	\$ 22,304	\$ 22,977
<b>Total</b>	<b>\$133,826</b>	<b>\$137,860</b>

The evaluation team is prepared to continue conducting rigorous capacity building and technical assistance to help agencies develop sustainable evaluation tools and competencies to best serve their reporting, programming, and service goals and objectives.

The majority of the proposed work is focused on training development and implementation; mentoring, technical assistance, coaching, and consultation; collaboration with the Boards; continuous assessment of needs and readiness; project management; and reporting. We will leverage UIUC resources including the Center for Innovation in Teacher and Learning (CITL), an online survey platform, Box, MediaSpace, and other in-kind resources available to FRC that are included in the cost proposal.

### **Personnel, Effort, and Roles**

Dariotis. Dr. Dariotis will have administrative oversight of the entire project including supervision of technical assistance implementation and evaluation design changes. She will develop microlearnings and in-person trainings on topics identified by agencies, Boards, working group members, and within her expertise (e.g., survey design and instrument development modules, participatory methods). She will attend board meetings, regularly update board staff on progress, and write annual reports.

Underland. Dr. Underland will provide support for the project including developing microlearnings and trainings on topics within his expertise (e.g., storytelling, reporting) and support website needs.

Eldreth. Dr. Eldreth will serve as lead data manager and online programmer (e.g., survey programming) as well as provide technical assistance and develop online microlearnings. She will attend board meetings (as needed) and assist in report writing.

Jackson-Gordon. Dr. Jackson-Gordon will lead project management and continued readiness and needs assessment, and technical assistance sessions with chosen agencies. She will develop in-person trainings and microlearnings on identified topics within her expertise (e.g., measurement, participatory methods). She will attend board meetings, regularly update board staff on progress, and write annual reports.

Sloane. Dr. Sloane will provide secondary support for data management needs and online programming, provide technical assistance support, and develop online microlearnings.

Postdoc/ graduate research assistant. A graduate research assistant will assist with data collection and technical assistance sessions with chosen agencies. They will support the development and implementation of microlearnings and in-person trainings.

### **Materials/ Supplies**

Funds are allocated for Years 3 and 4 for materials and supplies to support trainings (e.g., post-its, markers, flipcharts, food, etc.).

### **Honoraria**

Funds are allocated in Years 3 and 4 for working group member honoraria for participating in biweekly or monthly working group meetings.

## Scope of Work

### Proposed Activities – Evaluation Plan

We will *accomplish the following proposed activities*:

1. **On-demand microlearnings and virtual/ in-person trainings.** Continue creating a resource bank of on-demand microlearnings that all Board and Agency personnel can access. These will be archived so that they can be reached at any time. On-demand recordings will range in length from ~5 minutes to 1 hour (at most), depending on topic area. In-person and virtual trainings will be offered for identified topic areas needing more instruction and hands-on practice than microlearnings can offer. We anticipate 2-4 microlearnings and 1-2 intensive workshop trainings per year.

Example training topics are below (Note: final choices will be informed by the results of the readiness and needs assessments and made in consultation with Boards):

- a. *Evaluation Capacity Knowledge* – e.g. how to develop an evaluation plan
  - b. *Evaluation Capacity Skills* – e.g. how to choose appropriate data-collection methods and instruments
  - c. *Leadership* – e.g. how to apply principles of team science and participatory research
  - d. *Culture* – e.g. how to apply culturally appropriate evaluation approaches
  - e. *Systems and Structures* – e.g. how to coordinate a readiness assessment to identify current and future system and infrastructure needs to attain goals and meet deliverables.
  - f. *Communication* – e.g. how implement best practices in reporting and storytelling
2. **Automated Processes and Efficiencies.** Identify opportunities within existing systems to create efficiencies through automated processes. Help Boards design and develop user-friendly, automated systems (e.g., templates for inputting data and generating reports with figures and tables necessitating minimal reformatting; programming outcome indicator instruments into online survey platforms that calculate results and create reports for agencies), as needed and appropriate.
  3. **Intensive Technical Assistance (TA).** Up to three agencies will be chosen, in consultation with the Boards, for one-on-one TA experiences.
  4. **Train-the-Trainer (TTT).** Develop a cross-agency mentoring approach to enhance the transfer of learning and leverage sustainable evaluation practices. Continue the working group, recruit new members, and move toward a community of practice.

### Deliverables

1. Annual report
  - a. Description of evaluation capacity building activities and progress
  - b. Recommendations for agencies, Boards, and evaluation team for subsequent year

(e.g., areas for automated processes, efficiencies, resources/ tools)

- c. Implementation of metrics for agency intensive technical assistance and cross-agency mentoring program
2. Microlearning repository (asynchronous learning)
3. Virtual. in-person workshops/ trainings
4. Intensive technical assistance with up to three target agencies, annually
5. Measures bank (programmed into an online survey platform, if preferred and feasible)
6. Cross-agency mentoring program

# Briefing Memorandum

DATE: March 19, 2025  
TO: Champaign County Developmental Disabilities Board (CCDDB)  
FROM: Kim Bowdry, Associate Director for I/DD  
SUBJECT: Program Year 2024 Service Activity Data

## Background

At the beginning of PY2018, CCDDB staff implemented a new data collection system for programs serving people with I/DD. Funded programs began entering service claims into the Online Reporting System for the types of services provided to people served. Since this implementation, agencies have continued providing a higher level of detail about client specific service activities than before.

Prior to PY2021 reporting categories were changed at the request of a CCDDB member. New categories focus on a client's presence with staff during the time entered as a claim and where the service activity took place. These new claims were entered as 'With Person Served' or 'On Behalf of Person Served.' Both new service options could be associated with one of the following place options, 'Off Site (in the community or client home)' or 'On Site (at an agency facility)'. At this time units of service were changed from quarter hour entries to full hour entries. While using full hours of service may give an appearance of over service in some cases, it provides a more accurate description of service and was also meant to prevent agency staff from spending as much time entering claims. This method of reporting also provides a clearer representation of services provided by CCDDB funded programs than before PY2018.

## CCDDB Funded Program Information

'Utilization Summaries for PY2024 CCDDB and CCMHB I/DD Programs' is attached for reference. This document was included in the October 23, 2024 CCDDB packet. Programs listed below reported service activity data for specific people served. PY2024 totals are listed by program.

### **CCRPC**

- Decision Support Person Centered Planning served 131 people for a total of 6,435 hours, with total payments of \$433,777.

## **Community Choices**

- Community Employment served 52 people for a total of 2,938 hours, with total payments of \$226,500.
- Inclusive Community Support served 35 people for a total of 2,185 hours, with total payments of \$198,000.

## **DSC**

- Clinical Services served 68 people for a total of 1,390 hours, with total payments of \$241,000, \$3,780 of which was returned as unspent revenue.
- Community Employment served 83 people for a total of 7,506 hours, with total payments of \$450,606.
- Community First served 50 people for a total of 35,804 hours, with total payments of \$890,042.
- Community Living served 78 people for a total of 15,103 hours, with total payments of \$565,480.
- Connections served 30 people for a total of 1,536 hours, with total payments of \$106,400.
- Individual and Family Support served 42 people for a total of 6,938 hours, with total payments of \$250,000. \$19,036 was returned as unspent revenue.
- Service Coordination served 256 people for a total of 4,975 hours, with total payments of \$496,080, of which \$34,484 was returned as unspent revenue.

## **PACE**

- Consumer Control in Personal Support registered 20 PSWs, with total payments of \$36,000. The program also matched 8 Personal Support Workers (PSWs) to people with I/DD seeking PSWs.

As in previous years, not all programs reported client level data as claims in the Online Reporting System. These programs are listed below. Two programs serve a significant number of Non-Treatment Plan Clients and do not report client level data on these services. For the programs below, this information can be found in the attached 'Utilization Summaries for PY2024 CCDDDB and CCMHB I/DD Programs' document.

## **Community Choices**

- Self-Determination Support, \$171,000

- Transportation Support, \$119,500

## DSC

- Employment First, \$90,100. \$27,797 was returned as unspent revenue.

## Programs and People with Service Level Data

- Of the programs reporting on specific individuals and service activities, there were **375 unduplicated adults or older children** and **720 young children**.
- Of the unduplicated adults and older children served during PY2024, **48% had state waiver funding as well, due to billing restrictions through IDHS-DDD waiver programs**.
- Of the unduplicated adults and older children served during PY2024, **52% had DDB/MHB funding only**.
- An individual may receive services from more than one agency and more than one program within a single agency. All adult TPCs in CCDDDB funded programs should also be enrolled in CCRPC's Decision Support PCP program, receiving Conflict Free Case Management, or be enrolled in Medicaid waiver funded services. There was **no** overlap of adults or older children, and only 2 young children had a minor overlap in services.
  - 259 (410 in PY2023) people were served by **one agency only**;
  - 108 (154 in PY2023) people were served by two agencies; and
  - 3 (4 in PY2023) people were served by three agencies.
  - 156 people (335 in PY2023) were served in **one program only**;
  - 104 (118 in PY2023) people were served in two programs;
  - 51 (54 in PY2023) people were served in three programs;
  - 34 (36 in PY2023) people were served in four programs;
  - 11 (12 in PY2023) people were served in five programs;
  - 9 (11 in PY2023) people were served in six programs; and
  - 3 people were (2 in PY2023) served in seven programs.
  - Decreases from prior year are most likely due to CCRPC no longer serving as the ISC for Champaign County/counting people enrolled in PUNs.

## Profiles of People Receiving Services from Multiple Programs

Involvement with multiple agencies and multiple programs is often appropriate for each individual person's service needs and preferences. The need or preference for multiple agencies and/or program involvement should be documented in each person's person-centered plan. Below is a summary of agency and program involvement during PY2024.

- Of the **3 people served by three agencies**:
  - Two were served by CCRPC Decision Support PCP, Community Choices, and DSC.
  - One was served by CCRPC, DSC, and worked with PACE to hire a PSW.
  
- Three people who accessed **seven programs** were served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, Community Living, Connections, and Service Coordination with CCDDDB funding only.
  
- Of the **9 people served in six programs**:
  - 9 had CCDDDB funding only;
  - 2 people were served by CCRPC and DSC Community Employment, Community First, Community Living, Connections, and Service Coordination;
  - 2 people were served by CCRPC and DSC Clinical, Community First, Community Living, Connections, and Service Coordination
  - 1 person was served by CCRPC Decision Support PCP and DSC Clinical Services, Community First, Connections, and Service Coordination, and PACE Consumer Control in Personal Support (to hire a PSW);
  - 1 person was served by CCRPC, DSC Clinical, Community Employment, Community First, Connections, and Service Coordination;
  - 1 person was served by CCRPC, DSC Clinical, Community Employment, Community Living, Individual and Family Support, and Service Coordination;
  - 1 person was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, Connections and Service Coordination; and
  - 1 person was served by CCRPC Decision Support PCP, DSC Community Employment, Community First, Community Living, Connections, and Service Coordination.

- Of the **11 people served in five programs:**
  - 11 had CCDDDB funding only, two were selected from the PUNS list and working with Prairieland Service Coordination, Inc. (PSCI) to complete their Pre-Admission Screening for Medicaid Waiver funding;
  - 3 were served by CCRPC Decision Support PCP, DSC Community Employment, Community First, Connections, and Service Coordination;
  - 2 were served by CCRPC Decision Support PCP, DSC Community First, Community Living, Connections, and Service Coordination;
  - 1 was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, and Service Coordination;
  - 1 was served by DSC Clinical, Community Employment, Community First, Community Living, and Service Coordination (selected from the PUNS list and engaged in the PAS process with PSCI);
  - 1 was served by CCRPC Decision Support PCP, DSC Community Employment, Community Living, Individual and Family Support, and Service Coordination;
  - 1 was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community Living, and Service Coordination;
  - 1 was served by DSC Community Employment, Community First, Community Living, Connections, and Service Coordination (selected from the PUNS list and engaged in the PAS process with PSCI); and
  - 1 was served by CCRPC Decision Support PCP, Community Choices Customized Employment, DSC Community First, Connections, and Service Coordination.

## Samples of Total Hours of Services by Program

Client level data can be found below. This data provides examples of how people with I/DD in Champaign County utilized the programs funded by the CCDDDB for PY2024.

- Person A participated in **7 programs, 2 agencies:**
  - 56 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 49 hours of service from DSC Clinical Services, 4% of total program hours;
  - 237 hours of service from DSC Community Employment, 3% of total program hours;

- 419 hours of service from DSC Community First, 1% of total program hours;
  - 110 hours of service from DSC Community Living, <1% of total program hours;
  - 23 hours of service from DSC Connections, 1% of total program hours; and
  - 24 hours of service from DSC Service Coordination, <1% of total program hours.
- **Person B participated in 6 programs, 3 agencies:**
    - 41 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
    - 4 hours of service from DSC Clinical Services, <1% of total program hours;
    - 63 hours of service from DSC Community First, <1% of total program hours;
    - 21 hours of service from DSC Connections, 1% of total program hours; and
    - 3 hours of service from DSC Service Coordination, <1% of total program hours.
    - 3 Successful Matches with PSWs through PACE Consumer Control in Personal Support.
- **Person C participated in 5 programs, 3 agencies:**
    - 64 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
    - 122 hours of service from Community Choices Customized Employment, 4% of total program hours;
    - 482 hours of service from DSC Community First, 1% of total program hours;
    - 85 hours of service from DSC Connections, 6% of total program hours; and
    - 17 hours of service from DSC Service Coordination, <1% of total program hours.
- **Person D participated in 4 programs, 2 agencies:**
    - 67 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
    - 26 hours of service from DSC Community Employment, <1% of total program hours;

- 1,156 hours of service from DSC Community First, 3% of total program hours; and
  - 10 hours of service from DSC Service Coordination, <1% of total program hours.
- Person E participated in **3 programs, 2 agencies**:
    - 98 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
    - 100 hours of service from DSC Community Living, <1% of total program hours; and
    - 27 hours of service from DSC Service Coordination, <1% of total program hours.
- Person F participated in **3 programs, 2 agencies**:
    - 12 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
    - 122 hours of service from Community Choices Customized Employment, 4% of total program hours; and
    - 7 hours of service from Community Choices Inclusive Community Support, <1% of total program hours.
- Person G participated in **2 programs, 2 agencies**:
    - 85 hours of service from CCRPC Decision Support PCP, 1% of total program hours; and
    - 29 hours of service from Community Choices Inclusive Community Support, 1% of total program hours.

## Samples of Total Hours of Services by Program by Client

Specific client level data can be found below for one client. This data provides a comparison of how one person with I/DD utilized programs funded by the CCDDDB from **PY2018-PY2024**. PY2018 may show partial year reporting for some programs listed below as agencies transitioned to using the Claims System. Claims from PY2018-PY2020 were reported as quarter hours, and reporting categories were more specific than the updated claims used since PY2021.

- Person H participated in 4 programs, 2 agencies during **PY2018** with CCDDDB funding only:

- 1.75 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 126.25 hours of service from DSC Apartment Services (currently Community Living), 3% of total program hours;
  - 52.25 hours of service from DSC Community Employment, 4% of total program hours; and
  - 12 hours of service from DSC Service Coordination, <1% of total program hours.
- Person H participated in 4 programs, 2 agencies during **PY2019** with CCDDDB funding only:
    - 3 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
    - 166 hours of service from DSC Apartment Services (Community Living), 2% of total program hours;
    - 86.5 hours of service from DSC Community Employment, 2% of total program hours; and
    - 17 hours of service from DSC Service Coordination, <1% of total program hours.
- Person H participated in 5 programs, 2 agencies during **PY2020** with CCDDDB funding only:
    - 20.5 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
    - 143 hours of service from DSC Apartment Services (Community Living), 2% of total program hours;
    - 10 hours of service from DSC Clinical, 1% of total program hours;
    - 46.5 hours of service from DSC Community Employment, 1% of total program hours; and
    - 26.5 hours of service from DSC Service Coordination, 1% of total program hours.
- Person H participated in 5 programs, 2 agencies during **PY2021** with CCDDDB funding only:
    - 28 hours of service from CCRPC Decision Support PCP, <1% of total program hours (9 hours were ‘With Person Served’ [direct service] and 11 hours were ‘On behalf of Person Served’ [indirect service]);

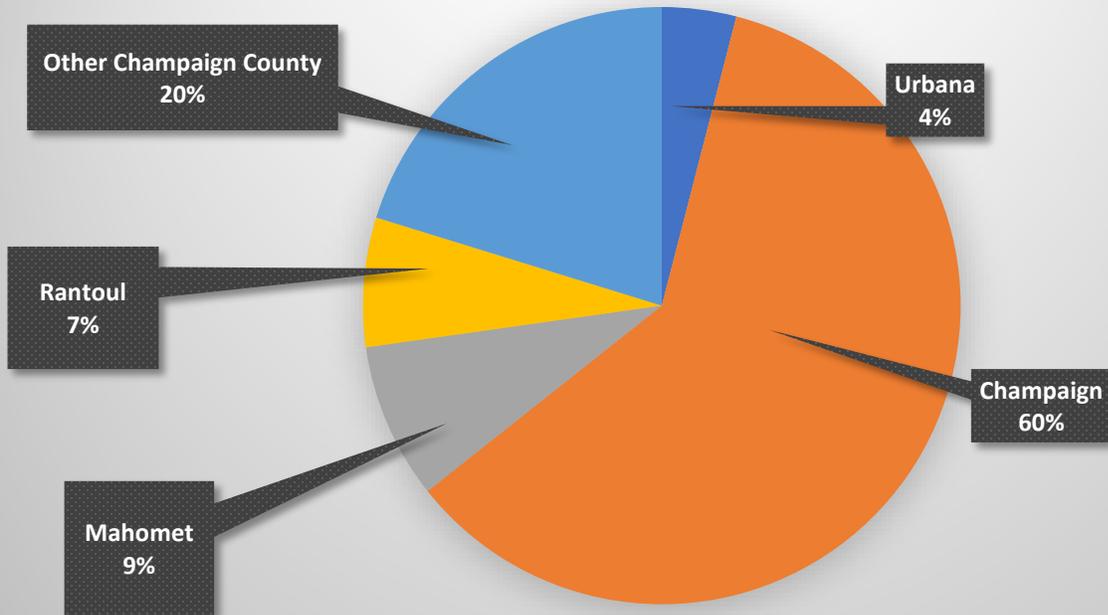
- 3 hours of service from DSC Clinical; <1% of total program hours (2 hours were 'With Person Served' [direct service] and 1 hour was 'On behalf of Person Served' [indirect service]);
  - 164 hours of service from DSC Community Employment; 4% of total program hours (119 hours were 'With Person Served' [direct service] and 45 hours were 'On behalf of Person Served' [indirect service]);
  - 208 hours of service from DSC Community Living, 2% of total program hours (175 hours were 'With Person Served' [direct service] and 33 hours were 'On behalf of Person Served' [indirect service]); and
  - 62 hours of service from DSC Service Coordination, 1% of total program hours (17 hours were 'With Person Served' [direct service] and 45 hours were 'On behalf of Person Served' [indirect service]).
- Person H participated in 5 programs, 2 agencies during **PY2022** with CCDDDB funding only:
    - 34 hours of service from CCRPC Decision Support PCP, 1% of total program hours (18 hours were 'With Person Served' [direct service] and 16 hours were 'On behalf of Person Served' [indirect service]);
    - 2 hours of service from DSC Clinical; <1% of total program hours (1 hour was 'With Person Served' [direct service] and 1 hours was 'On behalf of Person Served' [indirect service]);
    - 159 hours of service from DSC Community Employment; 4% of total program hours (129 hours were 'With Person Served' [direct service] and 30 hours were 'On behalf of Person Served' [indirect service]);
    - 149 hours of service from DSC Community Living, 2% of total program hours (63 hours were 'With Person Served' [direct service] and 86 hours were 'On behalf of Person Served' [indirect service]); and
    - 26 hours of service from DSC Service Coordination, <1% of total program hours (5 hours were 'With Person Served' [direct service] and 21 hours were 'On behalf of Person Served' [indirect service]).
- Person H participated in 5 programs, 2 agencies during **PY2023** with CCDDDB funding only:
    - 10 hours of service from CCRPC Decision Support PCP, <1% of total program hours (5 hours were 'With Person Served' [direct service] and 5 hours were 'On behalf of Person Served' [indirect service]);
    - 8 hours of service from DSC Clinical; 1% of total program hours (5 hours were 'With Person Served' [direct service] and 3 hours were 'On behalf of Person Served' [indirect service]);

- 91 hours of service from DSC Community Employment, 1% of total program hours (60 hours were ‘With Person Served’ [direct service] and 31 hours were ‘On behalf of Person Served’ [indirect service]);
  - 106 hours of service from DSC Community Living, 1% of total program hours (45 hours were ‘With Person Served’ [direct service] and 61 hours were ‘On behalf of Person Served’ [indirect service]); and
  - 26 hours of service from DSC Service Coordination, <1% of total program hours (1 hour was ‘With Person Served’ [direct service] and 25 hours were ‘On behalf of Person Served’ [indirect service]).
- Person H participated in 4 programs, 2 agencies during **PY2024** with CCDDDB funding only:
    - 79 hours of service from CCRPC Decision Support PCP, 1% of total program hours (13 hours were ‘With Person Served’ [direct service] and 66 hours were ‘On behalf of Person Served’ [indirect service]);
    - 153 hours of service from DSC Community Employment; 2% of total program hours (110 hours were ‘With Person Served’ [direct service] and 43 hours were ‘On behalf of Person Served’ [indirect service]);
    - 203 hours of service from DSC Community Living, 1% of total program hours (60 hours were ‘With Person Served’ [direct service] and 143 hours were ‘On behalf of Person Served’ [indirect service]); and
    - 22 hours of service from DSC Service Coordination, <1% of total program hours (22 hours were ‘On behalf of Person Served’ [indirect service]).

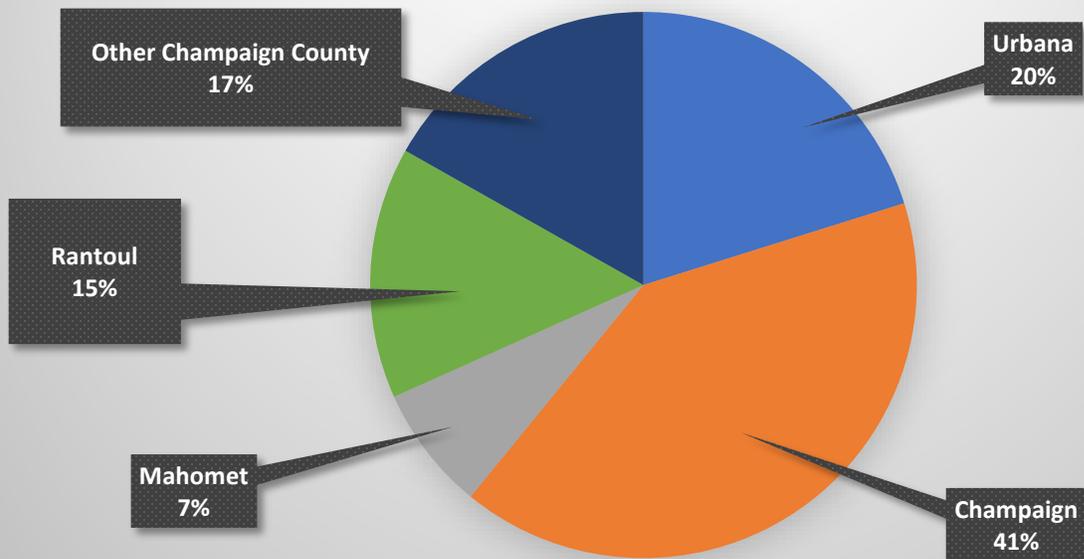
## Characteristics of People Served through CCDDDB and CCMHB I/DD Funding for PY2024

Included below are charts of aggregate agency service data per demographic category and residency, total hours of service by program, and total hours of service by type.

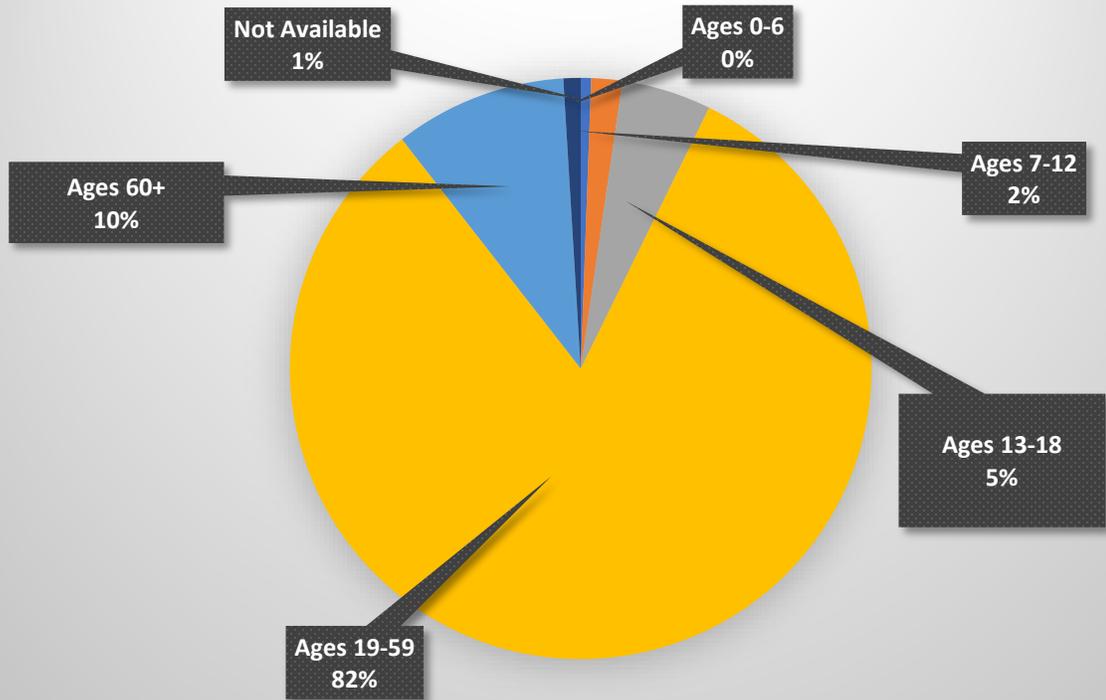
### PY24 CCDDDB Funded Program Client Zip Code Data



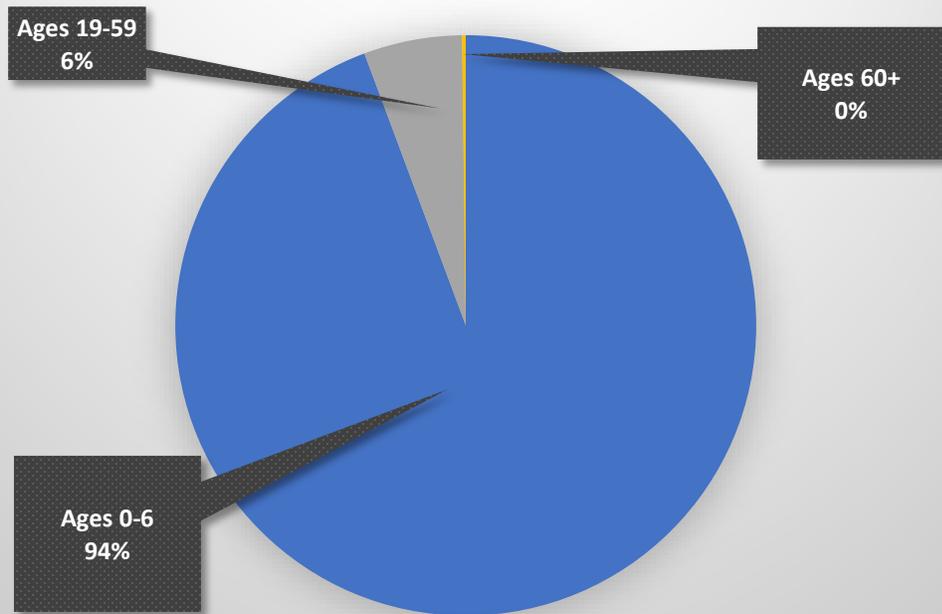
### PY24 CCMHB I/DD Funded Program Client Zip Code Data



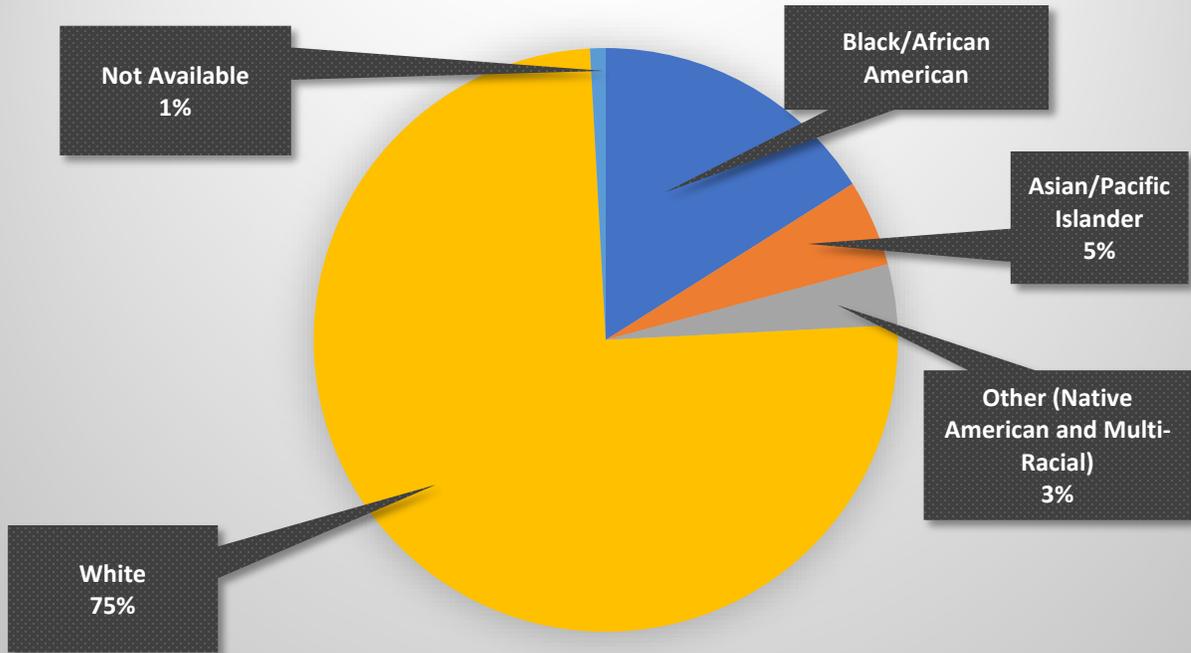
### PY24 CCDDDB Funded Program Client Age Data



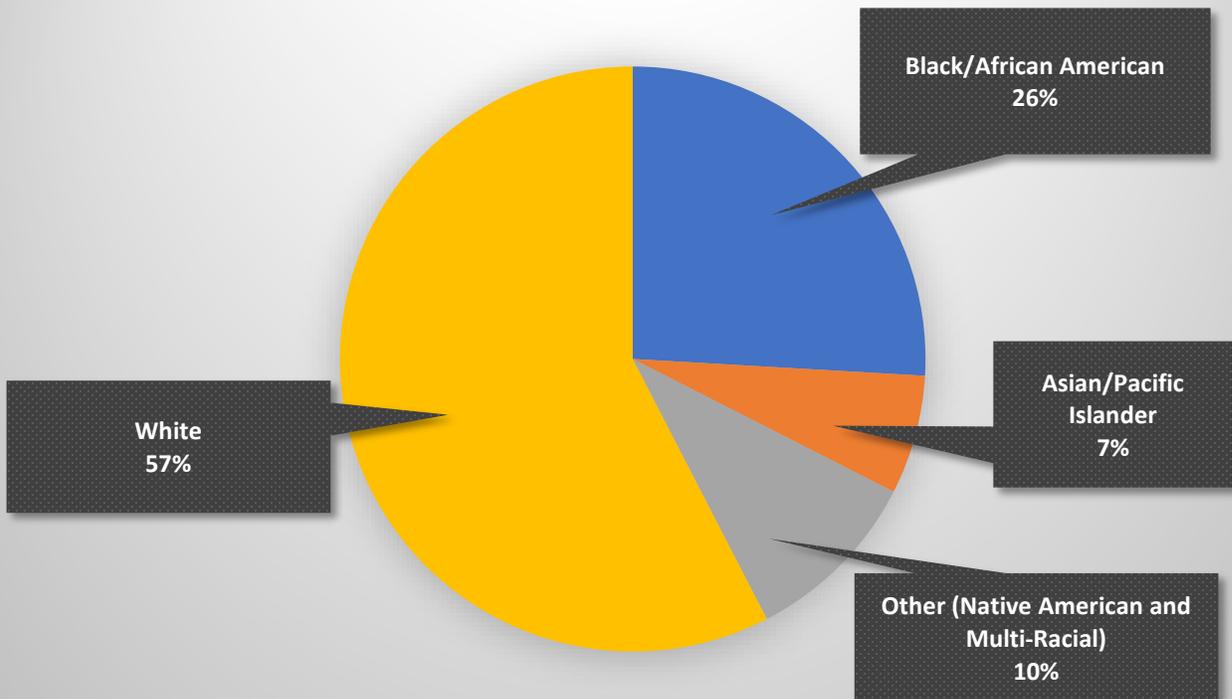
### PY24 CCMHB I/DD Funded Program Client Age Data



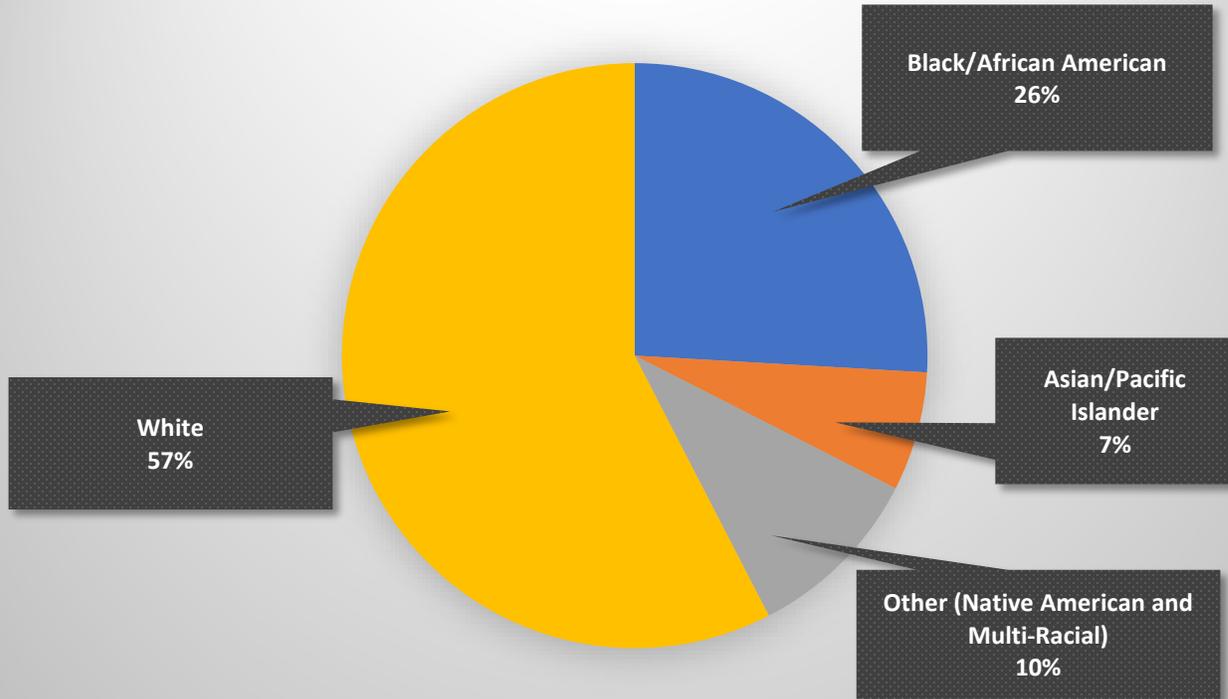
## PY24 CCDDDB Funded Program Client Race Data



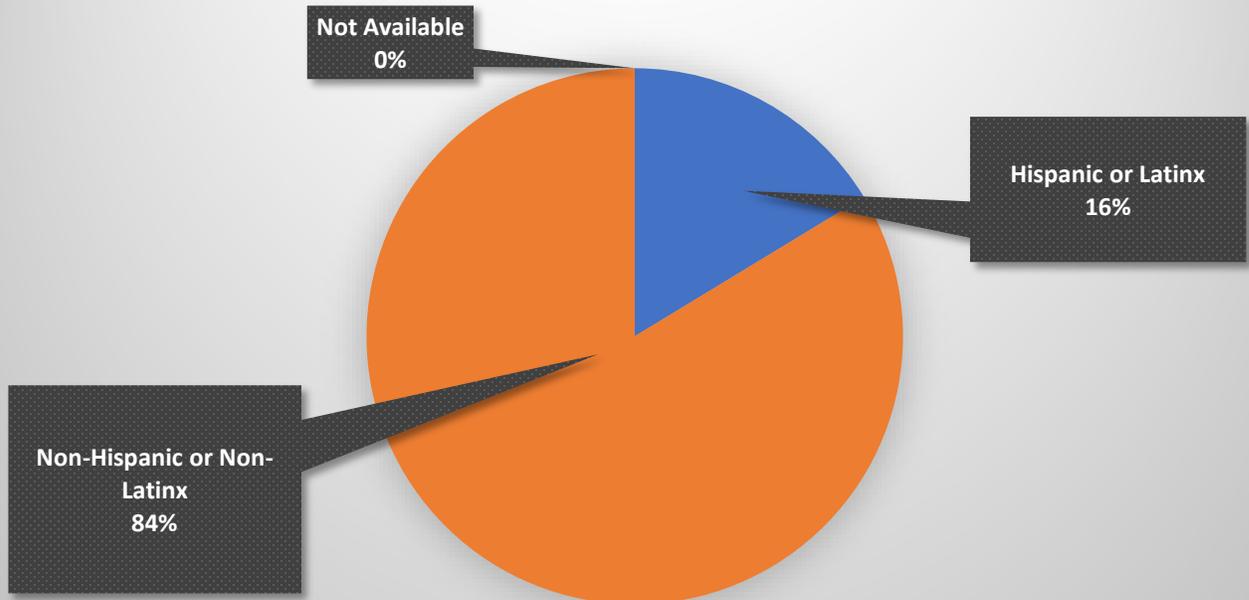
## PY24 CCMHB I/DD Funded Program Client Race Data



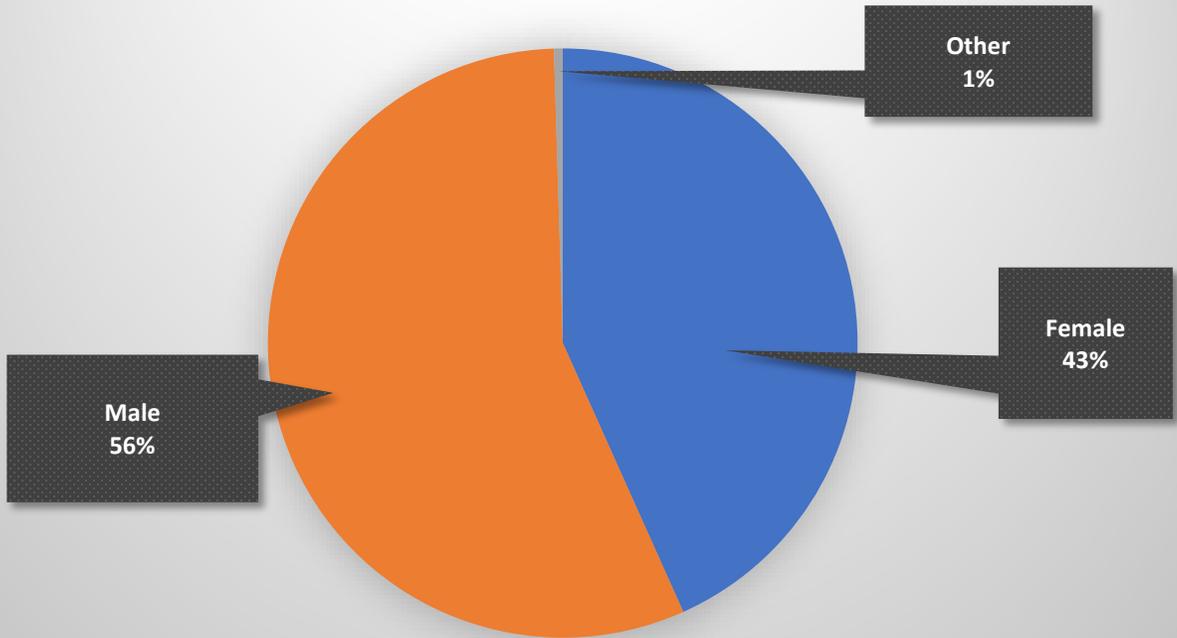
## PY24 CCMHB I/DD Funded Program Client Race Data



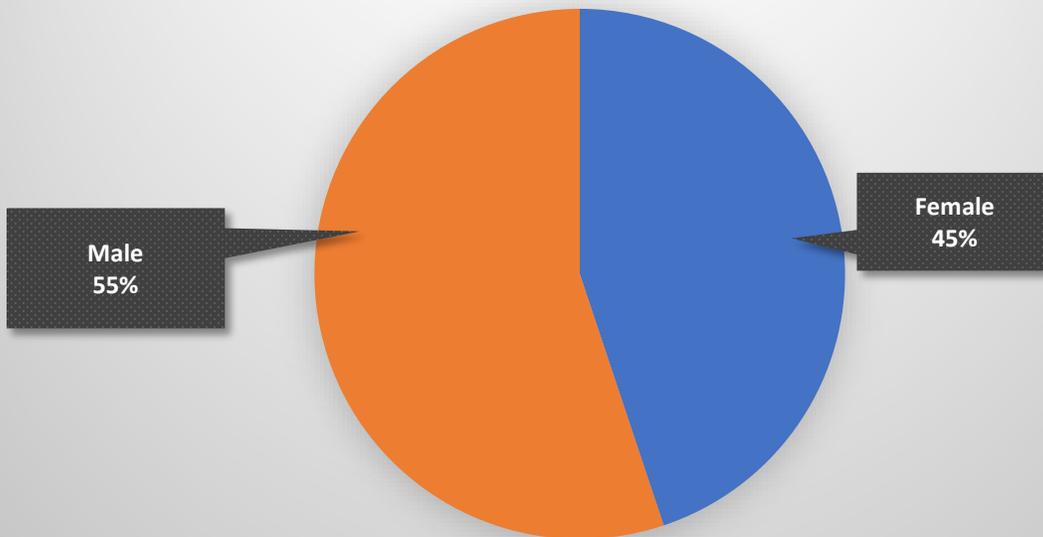
## PY24 CCMHB I/DD Funded Program Client Ethnic Origin Data



### PY24 CCDDDB Funded Program Client Gender Data



### PY24 CCMHB I/DD Funded Program Client Gender Data





## **BRIEFING MEMORANDUM**

DATE: March 19, 2025  
TO: Champaign County Developmental Disabilities Board (CCDDB)  
FROM: Leon Bryson, Associate Director  
SUBJECT: Results of Agency Survey on Emerging Threats

### **Background and Purpose:**

Service providers and stakeholders had been expecting hardship in 2025, due to the loss of ARPA funds and likely reductions in State of Illinois appropriations for human services. It is difficult enough for all to plan for these, but the first few months of 2025 federal activities complicated expectations even more.

Among Executive Orders issued by President Trump are some directing changes to funding and regulatory systems many rely on. Changes included elimination of diversity, equity, and inclusion initiatives and a ‘freeze’ on payment disbursement for thousands of government grant and loan programs, impacting millions of individuals. A new department has terminated thousands of federal employees, many administering programs relevant to our work, and the US House and Senate negotiations on budget reconciliation appear poised to destroy Medicaid. States, local governments, and other agencies rely on public funds to provide childcare, housing support, food assistance, education grants, law enforcement and public safety supports, mental health and substance use treatment, and services for the elderly, people with disabilities, veterans, active-duty members of the military, and rural families, to name a few.

While we wait for resolution of major budget decisions and implementation of federal executive orders, local service providers might already see impacts on their staff or clients and may be facing a reduction in force or service capacity.

On February 18th, CCDDB-CCMHB staff launched a brief survey to see how these emerging changes may affect agencies and the people they serve. The survey was anonymous, completely optional, and results were kept confidential. Agencies and other stakeholders received an email containing a link to the Google Forms survey. The survey took no longer than 10 minutes to complete and had a deadline of March 7th. The results are attached.

# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.  
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Unknown. Are in a watch and wait situation.

Current or anticipated effects on the people you serve:

Same

Current or anticipated effects on resources your staff or clients rely on:

Same

Other details we should know:

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Federal websites down, inactive.

Current or anticipated effects on the people you serve:

Same

Current or anticipated effects on resources your staff or clients rely on:

Same

Other details we should know:

Cannot access critical healthcare information from immunizations, sexual health, etc..

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

## Current or anticipated effects on your staff:

At this time we are not experiencing any effects, other than the stress and uncertainty of the current state of human services.

## Current or anticipated effects on the people you serve:

If medicaid waivers (DDD and DRS) are affected by cuts, that would have an impact on our agency's funding and budget. It would also have a huge impact on the ability of many, many people with I/DD to ensure their basic needs are met. If funding for HBS were interrupted, it would eliminate support for many people for example. And for many people working in the I/DD field, work as PSWs directly employed by people or families is their main source of income. Interruption could put their financial security at great risk.

## Current or anticipated effects on resources your staff or clients rely on:

Our clients are often some of the most vulnerable citizens. They rely on a robust social services system - medicaid, medicare, social security, waiver services, food stamps, housing vouchers, LIHEAP, ADA protections, etc. It seems that all of these things are at potential threat from our current administration. As individuals who frequently do not have a strong safety net, changes or the elimination of any of these programs could have monumental affects. That would put additional pressure on our local systems to be able to support people with fewer and fewer resources.

## Other details we should know:

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Federal funding cuts will cause our staff to drop to 50% FTE

Current or anticipated effects on the people you serve:

Our housing will lose funding, displacing several immunocompromised individuals, some with several medical conditions.

Current or anticipated effects on resources your staff or clients rely on:

Our office and food pantry are located in our transitional housing facility. If there are federal funding cuts, our staff will lose their workspace, and we will be forced to discontinue our food pantry.

Other details we should know:

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# Emerging Threats Survey

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We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

If federal cuts happen, unfortunately, staff cuts may become a real possibility

Current or anticipated effects on the people you serve:

If federal grant for lifespan respite is cut, this will effect all caregivers statewide caring for a loved one of any age with any disability not being able to receive an emergency respite stipend. The IRC will continue to work on grant objectives to improve respite statewide but funding cuts will result in the lack of emergency respite funding.

Current or anticipated effects on resources your staff or clients rely on:

From July through January, over 275 caregivers were supported by a voucher stipend and linked to longer term more sustainable support.

Other details we should know:

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

.....

Current or anticipated effects on the people you serve:

More poverty, less housing

.....

Current or anticipated effects on resources your staff or clients rely on:

Reduction in gra t monet

.....

Other details we should know:

Prison population likely to grow.

.....

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

## Current or anticipated effects on your staff:

There are not currently or any anticipated effects to our staff as long as our funding sources for operations are not affected.

## Current or anticipated effects on the people you serve:

The anticipated effects to the people we serve depends on possible reductions/suspension to the EFSP and USDA food programs, both of which could significantly reduce the amount of food we have to distribute.

## Current or anticipated effects on resources your staff or clients rely on:

For our clients, we are concerned about possible reductions/suspension to the EFSP food funding and USDA commodities distributions, both of which will greatly reduce the amount of food we have to distribute. For our staff, the effects are none as long as our funding sources for operations are not affected.

## Other details we should know:

If agencies that see clients here onsite are effected, there will be client impacts. We are watching all the changes being made very carefully and are unsure, at this time, of all the possible effects long term.

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# Emerging Threats Survey

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We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

We don't have federal funding

Current or anticipated effects on the people you serve:

N/A

Current or anticipated effects on resources your staff or clients rely on:

I'm not sure. I have only heard from some providers. I don't think anyone knows for sure at this point.

Other details we should know:

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# Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.

We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Staff are concerned about their employment and the impact on their clients.

Current or anticipated effects on the people you serve:

Clients are at risk of facing reduced services and longer waiting times for therapy.

Current or anticipated effects on resources your staff or clients rely on:

Support for transportation, clothing, and agency supplies are all likely to be impacted.

Other details we should know:

Our agency is at risk of losing about 20% of its budget and these funds are all used to support direct service staff. The agency is still working to make up for the loss of a quarter of the agency's budget at the start of FY24 that was a result of the actions of the first time this administration was in office.

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<b>CCDDB and CCMHB I/DD Funding Requests for PY2026</b>			
<b>July 1, 2025 through June 30, 2026</b>		<b>Requests</b>	<b>Primary/Secondary</b>
		<b>PY26</b>	
<b>Agency</b>	<b>Program Name</b>	<b>all 3 funds</b>	<b>Reviewer</b>
<b>Priority: Advocacy and Linkage</b>			
CCRPC - Community Services	Decision Support PCP	\$425,042	VN/AR
DSC	Service Coordination	\$500,000	KF/SF
The Autism Program at UIUC	The Autism Program UIUC	\$87,186	SF/NS
<b>Priority: Home Life</b>			
Community Choices, Inc.	Inclusive Community Support (formerly Community Living)	\$233,000	NS/AR
DSC	Community Living (formerly Apartment Services)	\$628,000	AR/VN
<b>Priority: Personal Life</b>			
Community Choices, Inc.	Transportation Support	\$243,000	VN/KF
DSC	Clinical Services	\$263,000	SF/AR
DSC	Individual & Family Support	\$320,000	NS/SF
PACE	Consumer Control in Personal Support	\$45,972	AR/VN
Parkland College District 505	Parkland College OT at Head Start West	\$70,959	VN/NS
<b>Priority: Work Life</b>			
Community Choices, Inc.	Customized Employment	\$256,000	NS/KF
DSC	Community Employment	\$523,000	KF/VN
DSC/Community Choices	Employment First	\$102,500	VN/SF
<b>Priority: Community Life</b>			
Community Choices, Inc.	Self-Determination Support	\$228,000	AR/KF
DSC	Community First	\$990,000	SF/VN
DSC	Connections	\$122,000	KF/AR
CCRPC	Community Life Short Term Assistance	\$232,033	2 year - no review
<b>Priority: Strengthening the I/DD Workforce</b>			
Community Choices	Staff Recruitment and Retention	\$48,000	NS/KF
DSC	Workforce Development and Retention	\$244,000	2 year - no review
<b>Priority: Young Children and their Families (CCMHB focus)</b>			
DSC	Family Development	\$702,000	SF/KF
CC Head Start/Early Head Start	Early Childhood Mental Health Svcs (MH & DD)	\$241,135	2 year - no review
CU Early	CU Early	\$16,145	2 year - no review
	<i>(amounts listed are for DD portion of MHB contracts)</i>	-	
	<b>TOTAL</b>	<b>\$6,520,972</b>	
	<b>Total PY26 requests to all three funds and including two-year contracts = \$6,520,972</b>		
	MHB amount of \$939,944 = two year contracts totaling \$257,280 + \$682,664 to allocate in PY26		
	IDDSI two-year contract = \$232,033		
	<b>Total PY26 Requests for CCDDB Funds = \$5,348,995</b>		
	Early estimate of CCDDB PY26 Funds Available = \$5,188,916		
	High estimate = \$5,199,222		
	Difference of \$160,079 or \$149,773		

## CCDDB Application Review Checklist

### Minimal responsiveness (*staff confirm first*): Y/N concerns/comments

Eligible per questionnaire if new. Eligible per compliance if incumbent.		
Recent audit, review, compilation, or audited balance sheet if new. Recent audit or review with no concerns if incumbent.		
All application forms submitted on time.		
Relates to I/DD.		
Other pay sources have been maximized.		
Relationships with providers of similar or related services.		

### DDB Priority Categories: check appropriate

Advocacy and Linkage	_____
Home Life	_____
Personal Life	_____
Work Life	_____
Community Life	_____
Strengthening the I/DD Workforce	_____
Young Children and their Families (collaboration with CCMHB)	_____

### Best Value Considerations: Y/N concerns/comments

Is there a clear connection between the budget plan and the program activities?		
Are measurable, meaningful participant outcomes included? Are the access measures and utilization targets reasonable?		
Do the people served have a say in their own service plan? How are program activities impacted by people with I/DD?		
Does the program plan narrative add program-specific strategies (beyond the agency CLCP) to engage underserved populations?		
Does the application address whether and how rural residents may use the program?		
Is inclusion in the community described at the individual level? Through program activities?		
Does the application describe use of virtual supports and training?		
Is an evidence-based, evidence-informed, promising, or innovative approach identified?		
Are staff credentials/specialized training identified?		
Are other resources identified, with efforts to leverage them demonstrated?		

# Input from People with I/DD

*The following are from advocates working with the Going Home Coalition who gave GHC's coordinator, Carole Rosen, permission to share in this way.*

---

My name is Curtis Harris. I am a resident of Chicago, Illinois. I am a Medicaid Beneficiary. I live alone in an apartment in Chicago. The Medicaid supports I receive help me maintain my independence and work toward my goals.

Through Medicaid, a personal support work comes to my apartment weekly. For six years, my personal support worker has helped me set budgeting and personal goals for myself.

Without my support worker, I wouldn't have the support to build strategies and routines that help me stay focused on my goals and I would lose track of my goals.

Also through Medicaid, I visit a team of social workers once a week at a local provider. With these social workers, I can through what is going on in my life and I can get important guidance for moving forward and working through issues that I might face.

Medicaid plays an important role in my life. Without it, I would lose key supports that are helping me be successful in the community.

Curtis Harris  
Chicago, Illinois

---

*From Bob Peterson:*

3 Things I see as major issues for persons with disabilities:

1. Transportation – Without transportation people with disabilities have a hard time getting to and from work.

2. Employment – Employers do not often look to hire someone with a disability because they are worried about reliability.
3. DSP's – DSP's are essential because without them, people with disabilities cannot get up in the morning to go to work or do daily activities. They are essential to every aspect in the care of someone with a disability.
4. Voting – Society doesn't think that people with disabilities can vote because they can't get to the voting booths and that people with disabilities aren't capable of making important decisions like that.

---

*From Amy Foster:*

Dear Champaign county developmental disabilities and mental health board,

I was very excited when Carol sent me an email saying that you were looking for some ideas. Yes, I fall through the cracks of the system. I don't qualify for puns. Because even after a lifetime of being told, I have a developmental disability, I couldn't prove it. I would like for agencies to share some of their fun things I do with the broader disability community, whether or not they get services at that agency or not. I'm just so grateful that I can still be involved with Special Olympics Illinois.

Now I would like to tell you a few things about myself. I am the first one that they know of that has done the following from the department of mental health. I have become a certified recovery support specialist, a Recovery, action plan, facilitator, and a wellness recovery action plan educator.

I recently moved into my dream apartment in Columbia Illinois I work so hard for it. I use my networking skills myself advocacy skills and I connected with. I hope their housing which also helped me. Other ones that provided me with the simple plain language law, they came into affect last year for fair housing. It's a reason why I live in a dream apartment. I love where I live.

---

# Lawsuit Filed By 17 States Threatens Disability Protections, Advocates Say

by Michelle Diamant | February 20, 2025

Over a dozen states are seeking to invalidate one of the nation's key disability rights laws, advocates are warning, jeopardizing access to health care, education and more.

A lawsuit brought by Texas and 16 other states is calling for an end to Section 504 of the Rehabilitation Act. The 1973 law bars discrimination on the basis of disability at any entity that receives federal funds.

The suit known as *Texas v. Becerra* was filed in response to an update to Section 504 regulations that was finalized by the Biden administration last year. With the litigation, the states are looking to ensure that gender dysphoria does not qualify as a disability under the rule. However, in challenging the regulations, the states' lawsuit asks the court to "declare Section 504, 29 U.S.C. § 794, unconstitutional" in its entirety.

"If this happens, it would be a disaster for disabled people and everything from education to employment would be negatively impacted," said Maria Town, president and CEO of the American Association of People with Disabilities.

Section 504 has a broad reach, extending to health care, public education, housing, transportation and much more, advocates say. While many students with disabilities are covered by the Individuals with Disabilities Education Act, federal figures show that 3% of students are served under Section 504 alone.

The latest 504 regulations clarified that medical providers cannot make treatment decisions based on disability biases, expanded the availability of accessible medical diagnostic equipment and set expectations for accessibility on providers' websites and mobile applications, among other changes.

If the court were to determine that Section 504 is unconstitutional, disability advocates are concerned that the basis of such a decision could also undermine other laws, including the Americans with Disabilities Act.

"If the judge were to adopt it, and actually declare the statute unconstitutional, it could portend that other anti-discrimination statutes based on race and sex and ethnicity are also unconstitutional for the same reason," Steven Schwartz, senior counsel at the Center for

Public Representation, said during a recent webinar. “And because there’s provisions in the regulations that tie together, that link 504 and the ADA, and prohibitions on race and sex discrimination, it links them all in how they’re enforced. Striking down the rule might imperil the ADA as well.”

Schwartz described that scenario as “simply frightening.”

Now, disability advocates across the nation are calling for states to back out of the litigation. And, facing significant pressure, the attorneys general are attempting to distance themselves from the suit’s request to overturn Section 504.

“Plaintiffs clarify that they have never moved — and do not plan to move — the court to declare or enjoin Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, as unconstitutional on its face,” reads a joint status report the states filed with the U.S. District Court for the Northern District of Texas on Wednesday.

The attorneys general indicated in the filing that they are continuing to evaluate their position in light of a recent executive order President Donald Trump issued on gender ideology. But, a statement from South Carolina Attorney General Alan Wilson’s office said that the filing is “a big step towards this lawsuit winding down and going away entirely.”

However, the latest filing is not easing concerns from advocates.

“Despite representations from several attorneys general that the lawsuit would be dropped, they’d withdraw from the lawsuit or they’d withdraw the constitutional challenge to Section 504, none of that occurred. They did not file an amended complaint, so the claims and scope of the case remain unchanged,” said Alison Barkoff, a professor at George Washington University who led the U.S. Department of Health and Human Services’ Administration on Community Living under the Biden administration.

Rather, Barkoff said that the filing actually doubles down on the states’ constitutional claim.

“As an example, they claim the rule’s requirement to provide services in the ‘most integrated setting’ consistent with the Supreme Court’s decision in *Olmstead v. L.C.* is unconstitutional,” Barkoff said. “If a court were to agree with them, not only would it undermine 25 years of progress through *Olmstead* enforcement but it would also mean that Section 504 would not apply to entities that receive federal health care, education, housing or transportation funding.”

In addition to Texas and South Carolina, the other states involved in the lawsuit are Alaska, Alabama, Arkansas, Florida, Georgia, Indiana, Iowa, Kansas, Louisiana, Missouri, Montana, Nebraska, South Dakota, Utah and West Virginia.

The case is currently paused, with another update expected in a month.

(Updated: February 20, 2025 at 11:20 p.m. ET)

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# Proposed Cuts May Put Medicaid Services On The Chopping Block

by Jordan Anderson, Pittsburgh Post-Gazette/TNS | February 19, 2025

PITTSBURGH — The future of Medicaid, the nation’s largest public health insurance program, hangs in the balance as House Republicans push for deep budget cuts that could drastically reshape it.

In Pennsylvania, where 3 million residents rely on Medicaid, advocates like Shana Jalbert, communications director of the Pennsylvania Health Access Network, worry about the vulnerable populations that stand to lose coverage.

Statewide, Medicaid covers about 40% of children and 33% of seniors, pregnant women and people with disabilities. The remaining 25% are low-wage workers without employer-provided insurance.

“That’s kind of the population we’re talking about when we’re talking about cuts,” she said. “It’s not a done deal yet. But what do we know is that any cut to the program, regardless of where it falls, will hit those populations hard.”

Embroided in a contentious budget reconciliation process, Congress is weighing how to cut federal spending by \$1.5 trillion over the next decade, in part to finance President Donald Trump’s extended tax cuts and increased border enforcement.

Experts warn that cuts to Medicaid are likely. Medicaid is the main program providing comprehensive health and long-term care to one in five Americans.

Of significant concern are proposals to restructure Medicaid funding by imposing a per-capita cap or converting it into a block grant, either of which could reduce federal Medicaid funding from between \$500 billion and \$800 billion over nine years, according to the Congressional Budget Office.

Laura Harker, a senior policy analyst with the Center for Budget and Policy Priorities, explained that a per-capita cap would force states to absorb “unpredictable” costs.

“Medicaid’s current structure ensures the federal government shares financial risk with states, which is especially crucial during economic downturns or public health crises,” Harker said.

As a result, states would likely cut eligibility and benefits. Optional services that states offer, such as community-based care for people with disabilities or even prescription drug coverage, could be among the first to be cut.

“The state would be on the hook for people with the most complex needs, and they can’t afford that,” Harker said. “Since states have to balance their budget and can’t go into a deficit, they would have to make cuts to coverage, cuts to benefits.”

Medicaid expansion, which extends coverage eligibility to more low-income adults, is also at risk. Pennsylvania opted into the expansion in 2015.

Currently, the federal government covers 90% of states’ costs for services covered under Medicaid expansion. But Congress is considering reducing the federal matching rate to the standard amount it provides for regular Medicaid services, which is 56% in Pennsylvania. According to the Center for Budget and Policy Priorities, Pennsylvania would need to find \$2.6 billion in 2025 to maintain that coverage, Harker said.

“In Pennsylvania, we’re looking at least 832,000 people were enrolled in the expansion group,” Harker said. “So that is putting coverage at risk for all those folks.”

Advocates like Jalbert argue that Pennsylvania residents will feel the impacts of lost coverage, one way or the other.

“If there’s a huge hole in the budget, that has to be either filled by cutting people off their health care or somehow finding the money by raising taxes on all Pennsylvania taxpayers,” she said.

‘It can affect them for life’

The potential cuts raise serious concerns for Cristina Codario, health policy director at Pittsburgh’s Allies for Children. The high percentage of Pennsylvania children covered by Medicaid makes it one of the most essential safety nets for low-income families.

“We’re talking about kids from families who make less than \$30,000 a year,” she said. “These are working parents, caregivers and even health care workers who don’t get employer-sponsored coverage.”

She highlighted that Medicaid ensures children receive critical screenings, including developmental and behavioral health assessments.

“One in three kids relies on Medicaid for early screenings that detect developmental delays and chronic conditions,” Codario said. “If we start cutting Medicaid, we risk missing these crucial windows for early intervention.”

Beyond individual health care, Codario said Medicaid funds school-based services in communities, including mental health care.

Should services and eligibility be scaled back, Pennsylvania does offer alternatives through its insurance marketplace Pennie, as well as the Children’s Health Insurance Program. But she said these programs can’t fully substitute for Medicaid.

“All kids can qualify for CHIP, but it operates on a sliding scale, meaning there are costs involved,” she said. “Not all families can afford those costs, even if they qualify.”

She said any instability in coverage could have long-term consequences for children’s health.

“We know that when kids experience gaps in coverage, it makes it harder for them to access preventive care, which can lead to worse health outcomes down the line,” Codario said. “Children are only young for so long. If they don’t get the care they need now, it can affect them for life.”

Mary Hartley, president of The Arc of Greater Pittsburgh, said Medicaid is essential for people with disabilities, providing medical services, therapy and other intensive supports.

She criticized proposals like per-capita caps, which would limit funding per individual, calling them unrealistic for families with complex health needs.

“I just spoke with somebody today who said, ‘My son was 9 months old when he hit his private insurance medical cap,’” Hartley said. “People don’t fit into caps. It doesn’t work that way.”

She also highlighted the strain already placed on Pennsylvania’s Medicaid system, with more than 12,000 people with intellectual disabilities and autism currently on waiting lists for services.

“Our state is already struggling to provide the services people need,” Hartley said. “We have older parents, 80 and 90-year-olds, caring for their senior adult children because they can’t get the supports they need. I can’t even imagine a cut. It would be devastating.”

For children with intensive medical conditions and disabilities, Medicaid covers early interventions like speech therapy, occupational therapy and sensory integration therapy — critical services that help them navigate school and social settings. Just over half of children with special health care needs have private insurance as their sole source of coverage.

The impact on adults would be just as severe. Many rely on Medicaid-funded home and community-based services, which allow them to live independently rather than being forced into institutional care.

“It ensure(s) they can be part of the community, to live, thrive, work, go to school and engage meaningful day activities,” she said. “These are individuals who used to go to segregated institutions. Not only is that not terrible care, it’s not the best option for any human being.”

“Years ago, most people with disabilities were sent to institutions, and families stood up and said, ‘No, we want our children to live in the community,’” Hartley said. “That’s what Medicaid’s services allow. It’s actually less expensive, and people have much improved lives knowing they can work, go to school, engage in meaningful everyday activities.”

And many families don’t have the financial resources to cover the high cost of private insurance, and even if they could, “there are no comparable services in the private industry,” she said.

Amid the fears of drastic rollbacks, Hartley emphasizes that public opinion remains favorable toward Medicaid and how it’s currently spent. A recent AP-NORC poll found that 55% of Americans believe the government spends too little on Medicaid, while only 15% think it spends too much.

“I think it’s politically thoughtful to consider why it’s so meaningful to voters,” she said. “We care about people we love who are funded and supported by Medicaid. Many people know the benefits and how it works in their lives.”

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# Champaign County, IL

## PROJECT BUDGET REPORT

FOR 01/01/2025 - 12/31/2025

Original Budget	Net Budget Amendments	Revised Budget	Requisitions	Encumbrances	Actuals	Available Budget	Percent Used
<b>Project: DisExpo - disability Resource Expo</b>							
E DisExpo	-COMM	-OPER SUPP					
	0.00	2,500.00	0.00	0.00	0.00	2,500.00	0.00%
E DisExpo	-COMM	-STA PRINT					
	0.00	5,000.00	0.00	0.00	147.10	4,852.90	2.94%
E DisExpo	-COMM	-Uniform					
	0.00	1,000.00	0.00	0.00	0.00	1,000.00	0.00%
<b>TOTALS for Phase/Source: COMM -</b>							
	0.00	8,500.00	0.00	0.00	147.10	8,352.90	1.73%
F DisExpo	-MISC REV	-OtherMisc					
	0.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
<b>TOTALS for Phase/Source: MISC REV -</b>							
	0.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
E DisExpo	-SERVICES	-JB REQ TRV					
	0.00	200.00	0.00	0.00	11.62	188.38	5.81%
E DisExpo	-SERVICES	-LEGAL ADV					
	0.00	5,000.00	0.00	0.00	0.00	5,000.00	0.00%
E DisExpo	-SERVICES	-PR					
	0.00	500.00	0.00	0.00	0.00	500.00	0.00%
E DisExpo	-SERVICES	-PROF SVC					
	0.00	50,000.00	0.00	0.00	2,500.00	47,500.00	5.00%
E DisExpo	-SERVICES	-Rent					
	0.00	12,500.00	0.00	0.00	0.00	12,500.00	0.00%
<b>TOTALS for Phase/Source: SERVICES -</b>							
	0.00	68,200.00	0.00	0.00	2,511.62	65,688.38	3.68%
<b>EXPENSE TOTALS for Project: DisExpo - disability Resource Expo</b>							
	0.00	76,700.00	0.00	0.00	2,658.72	74,041.28	3.47%
<b>FUNDING SOURCE TOTALS for Project: DisExpo - disability Resource Expo</b>							
	0.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
<b>TOTALS for Project: DisExpo - disability Resource Expo</b>							
	0.00	61,700.00	0.00	0.00	2,658.72	59,041.28	
<b>TOTALS FOR EXPENSE STRINGS</b>							
	0.00	76,700.00	0.00	0.00	0.00	2,658.72	1.09
<b>TOTALS FOR FUNDING SOURCE STRINGS</b>							
	0.00	-15,000.00	0.00	0.00	0.00	0.00	0.00

# Champaign County, IL

## PROJECT BUDGET REPORT

FOR 01/01/2025 - 12/31/2025

Original Budget	Net Budget Amendments	Revised Budget	Requisitions	Encumbrances	Actuals	Available Budget	Percent Used
REPORT TOTAL	Original Budget 0.00	Net Budget Amendments 61,700.00	Revised Budget 61,700.00	Requisitions 0.00	Encumbrances 0.00	Actuals 2,658.72	Available Budget 59,041.28