

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION

January 15, 2015 - 9:30 am to 1:00 pm  
United Way Conference Center, Room F  
1111 9<sup>th</sup> Street, Des Moines, Iowa  
MEETING MINUTES

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MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska	Brett McLain
Neil Broderick	Rebecca Peterson
Thomas Broeker	Michael Polich
Richard Crouch	Deb Schildroth
Marsha Edgington (by phone)	Patrick Schmitz
Lynn Grobe	Marilyn Seemann
Kathryn Johnson	Suzanne Watson
Geoffrey Lauer (by phone)	

MHDS COMMISSION MEMBERS ABSENT:

Representative Dave Heaton	Betty King
Representative Lisa Heddens	Sharon Lambert

OTHER ATTENDEES:

Pam Alger	DHS Targeted Case Management
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Kyle Carlson	Magellan Health Services
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS Targeted Case Management
Marissa Eyanson	Easter Seals Iowa
Connie Fanselow	MHDS, Community Services & Planning/CDD
Jim Friberg	Department of Inspections and Appeals
Jan Heikes	MHDS, Community Services & Planning
Deborah Johnson	Iowa Medicaid Enterprise, Long Term Care Bureau Chief
Liz O'Hara (by phone)	U of Iowa Center for Disabilities and Development
Caitlin Owens (by phone)	U of Iowa Center for Disabilities and Development
Rick Shults	MHDS Division Administrator
Deb Eckerman Slack	ISAC Case Management and MHD Services
Shane Walters	CEO, Sioux Rivers MHDS Region

WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:40 a.m. and led introductions. Quorum was established with twelve members present. No conflicts of interest were identified for this meeting. Jill Davisson has resigned her position on the Commission effective December 22, 2014 for health reasons.

## APPROVAL OF MINUTES

Deb Schildroth made a motion to approve the minutes of the December 4, 2014 meeting as presented. Richard Crouch seconded the motion. The motion passed unanimously. Neil Broderick, Marsha Edgington, and Geoff Lauer joined the meeting after the vote.

## SIOUX RIVERS REGIONAL MANAGEMENT PLAN

Jan Heikes, MHDS Community Systems Consultant, and Shane Walters, CEO of the Sioux Rivers Mental Health and Disability Services Region, presented proposed amendments to the Sioux Rivers regional management plan.

Last month changes to the Rolling Hills management plan were presented to the Commission to add Cherokee County to the Rolling Hills Region. The proposed changes presented today are to remove Cherokee County from the Sioux Rivers regional plan. Jan summarized the changes:

- Title page: Cherokee County removed and revision date changed to 1/1/15
- Page 3: Cherokee County emergency contact information removed
- Page 7: Cherokee County office removed from the list of regional offices
- Pages 14-15: "Brain Injury" removed as a category "Assistance to other than Core Populations"
- Page 35: Cherokee County removed from the application form

Patrick Schmitz asked Shane how the transition process has proceeded. Shane responded that Sioux Rivers misses the involvement of Cherokee County, but understands why they chose to move to the Rolling Hills Region, and indicated there has been no disruption of services to clients.

Deb Schildroth asked for more information about the removal of services for persons with brain injury. Shane responded that Cherokee County was the only county in the region that had ever covered services for brain injury and only one individual with BI had been served. Services for that person were no longer being funded at the time Cherokee changed regions.

Geoff Lauer said he thought that counties which had been providing services to people with brain injury were required to continue to do so by Senate File 2315. He said he objected to the removal of the brain injury service category on behalf of the BI constituency. Shane indicated that, with Cherokee no longer in the region, there are no counties that have been providing services to the BI population.

Jan clarified that these proposed changes have been reviewed by the Department, but will not be approved or denied by the Director until after the Commission makes its recommendation to him.

Deb Schildroth read the language from Senate File 2315, which says: “A region may provide assistance to service populations with disabilities to which the counties comprising the region have historically provided assistance but who are not included in the core services required under section 331.439D, subject to the availability of funding.” Deb noted that the language is “may,” rather than “shall,” so it is allowed but not required. She said she sees no distinction in the legislative language between services included when the region forms and changes made at a later time.

Geoff Lauer said that he still objects to the change and believes that in a regionally based system, the services should no longer be based on just one county. He said removing BI services is another step away from funding the brain injury population. Shane Walters explained that Cherokee County had had served only one individual, had capped the BI services it would provide to the amount for that individual, and no longer funded BI services because that individual’s services are now being funded in another way. He said that none of the other counties that comprise the region offer services to people with brain injury. Jan Heikes clarified that the regional policies covered the category of brain injury services, but the annual services and budget plan limited the dollar amount. She said that seven of the regional plans include brain injury in their services policies.

Motion – Deb Schildroth made a motion to recommend approval of the proposed changes to the Sioux Rivers regional management plan as presented. Tom Bouska seconded the motion. Geoff Lauer made a motion to modify the wording of the motion to recommend approval of the changes with the exception of the removal of brain injury services. Neil Broderick seconded the motion to modify.

Discussion - Geoff said that he believes that recommending approval of the removal of brain injury services from the plan would set a precedent for other regions to remove services. He said advocates fought to get the brain injury population recognized in county plans. Shane Walters said that for the region, the bottom line is that it is not mandated and it is their decision not to include it in the plan. He said it could be argued that the region has the funds to provide some brain injury services, but the region has chosen to spend the dollars available where they will have a much greater impact on many more people. He said they are focused on using funds to develop crisis services and revamp work activity centers. Rebecca Peterson commented that it would be misleading to leave it in the plan when the region does not intend to include it in the budget and fund the services. Geoff Lauer asked if the Sioux Rivers region funds persons with developmental disabilities. Shane responded that it does.

Vote – Patrick Schmitz called for a vote on the motion to modify to the original motion. Geoff Lauer and Marsha Edgington participated in the vote by phone. Geoff Lauer voted yes. The other 14 members present voted no. The motion failed. Patrick called for a vote on the original motion to recommend approval of the proposed changes to the Sioux Rivers regional plan. Fourteen members voted yes. One member, Geoff Lauer, voted no. The motion passed.

## MHDS/DHS UPDATE

Rick Shults said that the Governor's budget for fiscal years 2016-2017 has been released and he would like to share some context with the Commission. He said that there are many fixed costs built into the budget, including education, regents, tax relief, and other funding commitments that have already been made; those commitments leave very little discretionary room in the state budget as a whole.

Medicaid Growth - There has been significant growth in the state Medicaid program. Iowa's FMAP (Federal Medical Assistance Percentage), the share of Medicaid costs paid by the federal government, continues to go down because it is tied to economic indicators in each state and Iowa is doing better economically when compared to other states. States that are doing well economically are expected to pay a larger share. The state participation is capped at 50 percent. Iowa's FMAP for SFY (State Fiscal Year) 2015 is 56.14%, and for SFY 2016 will be 55.07%. Rick also explained that those percentages reflect a blended rate. The FMAP rate changes with the federal fiscal year (FFY) (October 1-September 30) and Iowa budgets for the SFY (July 1-June 30), so three months of one FFY rate have to be blended with nine months of another FFY rate to arrive at a blended rate for the SFY that is going to be slightly different than either of the federal FY rates. Rick said this will be a challenging year to meet the commitments already made, fund priorities, and balance the state budget, which must be balanced by law.

Deb Schildroth asked if there were still some enhanced match rates for particular services or programs. Rick responded that the rates he just quoted apply to the vast bulk of services, but there are some enhanced rates for limited purposes. He said, for example, right now the Iowa Health and Wellness Plan is almost entirely paid for with federal funds, but more responsibility will shift to the state over the next few years. Through the Balancing Incentives Program (BIP), Iowa received an additional 2% federal funding for a specific group of services for a defined period of time. That additional percentage will end next fall. Enhanced match rates apply to small, specific populations and for limited lengths of time. There is also an administrative match, which is another place where rates vary to some degree.

Kathy Johnson asked if that means the match rate for IHHs (Integrated Health Homes) will drop down from 90 to 55 percent at the end of the introductory period. Rick said he did not have that information and suggested posing the question to Deb Johnson when she arrives. [See bottom of page 13]

Equalization – The Governor's budget does not recommend the \$30 million for equalization to bring counties that are levying below the \$47.28 rate up to that amount. Rick said the Department will be working with the regions and ISAC (Iowa State Association of Counties) to get a clearer picture of the impact on counties. Teresa Bomhoff said she thought equalization funds were required by legislation that has already been passed. Rick responded that the funding is still subject to appropriation.

Mental Health Institutes - The Governor's budget did not recommend funding for the Mount Pleasant and Clarinda MHIs (Mental Health Institutes) in SFY (State Fiscal Year) 2016, which would mean there would no longer be services delivered in those facilities in SFY 2016.

Currently Mount Pleasant operates:

- 9 adult psychiatric inpatient hospital beds
- 19 beds for individuals with stable mental illness who need treatment for substance abuse (on average, 10 to 12 beds are in use)
- 50 residential treatment beds for substance use disorder (IRTC – Iowa Residential Treatment Center)

On average, only 10 to 12 of the 19 substance abuse beds are regularly in use and the last number of residents in the IRTC was about 33. Both units have substantially fewer people than beds. DHS will be working with the Department of Public Health to make sure people with substance use disorders (SUD) and dual diagnosis get the treatment services they need. The other two MHIs at Cherokee and Independence are expected to take on persons with mental health diagnoses who cannot be served elsewhere.

Currently Clarinda operates:

- 14 adult psychiatric beds
- 20 beds in a special geropsychiatric program

The 15-bed unit generally runs well below capacity, with seven beds in use today. There are currently 17 individuals in the geropsychiatric program. Clarinda is the only MHI with geriatric program that is specifically designed to provide long term care and operates like a nursing facility. There are some other geropsychiatric beds in the state, but not intended for long term care.

Teresa Bomhoff said she thinks it is a travesty to close the two MHIs. She said the public mental health system is continuing to close down beds and more and more people with mental illness are being moved into the corrections system, which is not good for them and is not cost effective. She said that not everyone with a mental illness is in a state of recovery that will allow them to live safely or independently in the community.

Rick Shults said that MHDS will be working with the Independence MHI to shift some inpatient bed capacity to them. He said that the recommendation is for their budget to increase and to add 20 to 25 additional adult inpatient psychiatric beds. Rick also noted that the superintendents at Mount Pleasant and Clarinda are also the wardens for the prisons located on the same campuses. The prisons and private programs on the Mount Pleasant and Clarinda campuses will remain in operation. Clarinda programs include the Clarinda Academy and Zion, a residential SUD treatment facility. Rick said DHS will be working with the community and others to find appropriate uses for the Mount Pleasant campus.

Richard Crouch commented that closing the two facilities will put an additional burden on sheriffs in the surrounding counties, who will have to travel much farther to take people to Independence or Cherokee.

Patrick Schmitz asked if the funds saved will be directed into community services to build capacity and help prevent hospitalizations. Rick responded that he has not been part of any discussion on that at this point. There is money being shifted to the Independence MHI to add beds, and Medicaid money will be used to serve the geropsychiatric patients elsewhere.

Suzanne Watson said that the geropsychiatric program is unique in Iowa and asked if there has been discussion about where the capacity is available to serve those individuals. She said she is aware that people usually enter the geropsychiatric unit because other nursing facilities have been unable to meet their needs and it is a difficult to serve population. She also noted that the Park Place facility in Glenwood is closing and there are about 90 people there who will need to be served in other settings that can handle difficult to serve populations. Rick said it will be challenging; the first and most direct way to serve people is through the Medicaid budget, but specific services may have to be developed.

Marissa Eyanson commented that providers who are willing to work with more difficult clients need to seek exceptions to policy to meet their needs, but have been seeing more exception being denied.

Rick said the decision not to continue funding to the Mount Pleasant and Clarinda programs is related to the difficulty and expense in maintaining large, older facilities, and the difficulty of hiring and retaining psychiatrists; it does not reflect on the quality of care or the work of the staff at the facilities. He said that the Council on Human Services included a recommendation to fund the facilities, but also indicated the Department should consider if services could be provided in a better way.

Modernization of Medicaid – Rick said the Department has been examining the best practices to deliver Medicaid services and are moving toward the expansion of care management. They are reviewing the scope of work and will be developing an RFP (Request for Proposal). He said he cannot talk about specifics during the RFP development process, but that information will be available when the RFP is released, sometime in the next few months. He said he would expect to see implementation starting in January of 2016.

MHDS Staff Positions - Theresa Armstrong said MHDS is close to filling two open staff positions. Interviews have been completed for a new Intellectual and Developmental Disabilities Specialist and negotiations are being finalized. A new CDD (Center for Disabilities and Development) staff person to work on outcomes is being hired and will be housed at MHDS. This person will work with providers and regions and analyze and distribute information. An individual has accepted the position and will be moving back to Iowa to start working in March.

Peer and Family Support RFP – The RFP for peer support and family support training and coordination has been awarded to the University of Iowa Center for Child Health Improvement and Innovation (CCHII), which is associated with the Child Health Specialty Clinics. The CHSCs have been involved in mentoring for Integrated Health Homes for children and will be working with CCHII on this new project, along with ASK Resource Center, NAMI of Iowa, and the University of Iowa School of Social Work, which is a national resource center for family-centered practice. Contract negotiations are still underway. DHS hopes to have the contract in place by the beginning of February.

Legislative Reports – A number of reports to the Legislature were due in December and January, including the Commission’s annual report. Other reports include:

- Autism Support Program Report – This report includes number of referrals, spending, and changes to the program. The funding began in FY14 for children age nine and under to receive ABA (Applied Behavioral Analysis) services if no funding is available through other sources. Magellan is administering the program, which started in April 2014. To date, there have been 14 applicants and seven applications have been approved. Reasons that applicants were not approved include being over age nine, or being eligible for ABA through Medicaid, or through private insurance.

The Regional Autism Panel meets on a regular basis. One of the barriers to accessing the program may be the age limit. Older children could benefit from ABA services. The limited number of Board Certified Behavior Analysts (BCBA) available in Iowa is also a barrier. They are not present in all parts of the state and more providers are needed. Telehealth has been used to help meet the need. Efforts will continue to reach more families through marketing and work with the stakeholder group to grow the program.

- Community Integration Workgroup for Adults with SMI Report – This workgroup focused on recommendations for improving community based services for people with serious mental illness. The Commission heard their recommendations at last month’s meeting. Their report was submitted in mid-December.
- Report on Employment Related Services and Supports Provided to Persons with Disabilities – This was a collaborative report. DHS and Iowa Vocational Rehabilitation (IVRS) have a memorandum of agreement, and there are multiple efforts by state agencies to work together on employment issues. The Iowa DD Council has the ICIE (Iowa Coalition for Integrated Employment) grant and work is being done to change the culture in schools to encourage employment and raise expectations for post-high school employment outcomes. Iowa is also participating in the Employment First State Leadership Program. During the last legislative session, IVRS received funding to draw down more federal matching funds. They are initially focusing on providing services to youth and young adults, school-age to age 23, to support them in moving from school to job training and development and on to HCBS Waiver or other services.

All DHS legislative reports are available at: <http://dhs.iowa.gov/legislative-reports>

## HCBS WAIVER OVERVIEW & UPDATE

Deborah Johnson, Bureau Chief for Long Term Care at Iowa Medicaid Enterprise, presented background and update information on Iowa's HCBS (Home and Community Based Services) Waiver program.

HCBS Waiver services started in Iowa in the early 1980s. They came about through the efforts of an Iowa parent, Julie Beckett, whose daughter, Katie, was born in 1978 and had significant health issues in the first few months of her life that required a high level of medical services and supports. At that time, she was eligible to receive Medicaid while she remained in a hospital or institution, but not if she went home. People who needed support in their communities were not Medicaid eligible. Katie's parents wanted to take her home and were prepared to care for her there, but could not receive any assistance from Medicaid or private insurance to make that possible, so she remained in the hospital until age three. Katie's mother eventually convinced President Reagan that it would be better and less expensive for everyone for Katie to be at home. She was granted her own special "Katie Beckett Waiver," which started a movement to change Medicaid policies during the 1980s to support others who were in similar situations. Hundreds of thousands of people in all fifty states are now being served through the same type of waiver. The aging population is a rapidly growing group.

These programs are called waivers because they allow certain specific Medicaid requirements to be waived. HCBS Waivers waive the requirement for where services can be provided and allow payment for services provided in home and community based settings that would otherwise be required to be provided only in institutions. The Medicaid requirement for statewideness can be waived. Because of that, specific targeted groups can be served, and specific services provided, rather than being required to have comparable services in all parts of the state as is required under regular Medicaid. States have to apply to the federal government for approval of their waiver programs and periodically for renewal of waiver programs.

There are three primary types of waivers:

- 1915c waivers are home and community based waivers; Iowa has seven
- 1915b waivers are managed care waivers; in Iowa, they include the Iowa Plan, administered through Magellan
- 1115 waivers are research or demonstration waivers that can be used to test new ways of delivering Medicaid services

In order to be eligible for HCBS Waivers (1915c), a person's needs have to meet the institutional level of care, which is comparable to someone entering a nursing facility, an ICF/ID, or a hospital. Waivers are meant to provide services in HCBS settings in lieu of an institution and individuals must have the choice. Institutional care is an entitlement; home and community based services are not. HCBS Waivers remove the requirement for a person to be in an institution and provide a choice between accessing services in

an institution or at home. Home based habilitation services are not considered an HCBS waiver; they are a Medicaid State Plan service. They fall under section 1915i, an HCBS State Plan option. The whole point of these programs is to expand options for services to individuals so that they do not have to go into institutions for care. A person must be Medicaid eligible to qualify for waiver services.

Deb shared a chart comparing the basic features of each waiver. She explained that in a facility, Medicaid pays a specific rate regardless of what the individual needs. In the waiver program, however, teams get together, look at the individual's needs, and determine how they can be met. The concept is to wrap the services around the person, use the natural supports available, and fill in the supports that are not available from other sources.

Target Populations - Iowa has seven 1915c Waivers for specific targeted populations:

- AIDS/HIV (no age limit)
- Brain Injury (no age limit)
- Children's Mental Health (under age 18)
- Elderly (age 65 or older)
- Health & Disability (under age 65)
- Intellectual Disability (no age limit)
- Physical Disability (ages 18 through 64)

Application – People apply for waiver services through their local DHS Income Maintenance Office.

Eligibility – Eligibility is determined by IME and must be reviewed at least once every 12 months, or whenever there is a significant change in the person's situation or condition. A special financial eligibility rule, called institutional deeming, is used for children. It considers only the income and resources of the child under age 18 and disregards the parents' income and resources. This allows children to get the services they need within the family.

Level of Care (LOC) – For each waiver, the person must meet an established level of institutional care, which means they have a level of need that would entitle them to be admitted to a particular type of facility. The chart shows the LOC requirements for each of the seven waivers, which include Hospital, NF (Nursing Facility), SNF (Skilled Nursing Facility), and ICF/ID (Intermediate Care Facility for Persons with Intellectual Disabilities).

Service Coordination - A case manager or service worker helps the person through the system. Waiver services cannot be funded retroactively, so it is important to help people move through the application process as quickly as possible. The service coordinator completes a service plan for each person on the waiver annually.

Dollar Limits - Each waiver has a maximum dollar amount available for services, as determined by the person's level of care. Cost increases are determined by the

legislature. The limits are different for each program because the cost must be compared to the aggregate institutional costs across the whole program. The waiver must cost less than the institutional cost. This is called the cost-neutrality requirement. The ID Waiver does not have a set monthly limit amount; the amount is based on the individual's service needs. The other waivers each have a monthly dollar cap. For example, the monthly cap for the Elderly Waiver for a person who needs a nursing facility level of care is \$1339. That is the maximum amount of funding available for a person with that level of care. The actual costs for most of the people utilizing that waiver average about half that amount. The cost of case management is not included in that monthly service amount.

Services - The chart also lists the program managers for each waiver and the services provided under each waiver. Deb said that HCBS Waivers are not intended to provide all the needs for each person, but to help support them in living at home. HCBS Waivers do not pay for room and board. The Consumer Choice Option (CCO) is a way for people to take self-direction another step. Those who use CCO develop and manage an individualized budget, and hire and fire their own support workers. Families often use it to hire their own respite workers rather than relying on Medicaid providers.

Teresa Bomhoff shared some information from LSA (Legislative Services Agency) on the average annual cost per person for each of the waivers in FY 2013:

- AIDS/HIV \$10889
- Brain Injury \$22353
- Children's Mental Health \$11617
- Elderly \$8824
- Health & Disability \$10356
- Intellectual Disabilities \$36021
- Physical Disabilities \$5872

Deb said that those costs are much less than they would be in an institution, and noted that there are going to be some people with a high level of need for whom the cost is greater. The Medicaid HCBS Program Comparison Chart, family packets, waiver waiting list information, and program contact information is available at:

<https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers>

Waiting lists – The federal government allows states to limit the number of people they serve based on the budget they set. Currently five of Iowa's seven waivers have waiting lists; the AIDS/HIV and the Elderly waivers do not. The waiting list for the ID Waiver was started just this month.

Applications for the ID Waiver are prioritized based on certain factors such as if a caregiver has died, if the person is homeless or is at high risk of institutionalization. For all the other waivers, applicants are served on a first come, first served basis according to their date of application. There has been a bill drafted this year to change to the use of prioritization for urgent or emergency needs for all the waivers.

Access to waiver services is tied to funding slots, so applicants are placed on waiting lists until funding slots become available for them. The current waiting list is about 9400 and will be going up to 10,000 soon. There is a constant need for more slots. It is not unusual for states to have large waiting lists for waiver services.

The way the process works:

- An applicant is notified when a slot is available
- The applicant has 30 days to respond
- If the applicant responds, the process continues
  - The applicant has to meet all eligibility requirements
  - The applicant works with a service coordinator to make a plan and find providers
  - The whole process can take two to six months
- If the applicant does not respond in 30 days, the slot is offered to the next person on the list

Only about 40 to 50 percent of applicants are eventually assigned waiver slots. The person may not meet the diagnostic or level of care criteria, they may have moved, or may have found other ways to access needed services. That means that from a waiting list of 10,000, it would be expected that 4000 to 5000 would actually meet the criteria for waiver services. Teresa Bomhoff asked there has been consideration of determining eligibility when an individual is put on the list. Deb responded that eligibility could be done at that time, but it would have to be redone when the slot became open because the need could be different at a different time. She said there are efforts do some basic screening at the time people apply. If an applicant is clearly not appropriate for waiver services, they should be referred to other resources. Teresa suggested that asking applicants a few key questions at the time of application might be helpful.

Deb said that Mathematica, a national policy research group, conducted a study called “Impacts of Waiting Periods for Home and Community-Based Services on Consumers and Medicaid Long-Term Care Costs in Iowa” and recommended prioritizing HCBS Waiver waiting list applications based on urgent or emergency need. The study is available online: <http://aspe.hhs.gov/daltcp/reports/2014/IAWaitPd.shtml#discuss>

Deb added that the state can target specific populations and save slots on a reserve capacity to serve that group. Iowa has some ID Waiver slots in reserve capacity for children who need 24/7 residential services and also for people who are coming out of ICFs/ID. The Money Follows the Person grant also helps transition individuals who want to leave ICFs/ID and move into the community. The BI and CMH waivers also have some reserve capacity.

Deb was asked to talk about the turnover in slots and how often slots become available because a person leaves the waiver. She said she did not have specific statistics for each one, but about 50 people per month are exited from the ID Waiver. Children on the CMH Waiver receive most of their services through Magellan and families use the Waiver to access respite services; most stay on the CMH Waiver for a relatively short

period of time, probably averaging about nine months. Most people on the BI Waiver stay on it indefinitely.

Last year, the Legislature appropriated \$6 million dollars to help reduce the HCBS Waiver waiting list. DHS has been working to release slots as quickly as possible, with consideration for the resources available. Deb explained that IME had to look at the number of people on waiting lists for all the waiver programs and determine how many additional people could be served with \$6 million. They estimated that about 1100 people could be added, which would mean they could give out about 2350 slots with a 40% to 50% uptake rate. The Department's effort began soon after the Governor signed the bill into law last year, and all of those slots are expected to be released by May. The first year that funding is available it is spent on Medicaid services, but not all of it is spent on services to new people, because there will still only be \$6 million to spend in FY 2016 and everyone who is added to a waiver slot will require ongoing funding. Applications have to be processed by DHS field staff, individual service plans have to be made, and providers have to be located and arranged. It takes time to get people onto waiver services and to build capacity in the service provider network. There is also still the same number of institutional beds, which also must be funded. Costs continue to grow; there has been a 13% increase in costs for the ID Waiver in the last year alone.

Kathy Johnson asked if there was an expectation that aging baby boomers would create an increased demand for the Elderly Waiver. Deb responded that there are many factors that come into play. There are many people who need services but do not want to access the Elderly Waiver because the waivers have a provision for estate recovery. It is challenging to project how many people will need the services and how many of those who are eligible will choose to access them through a waiver.

Deb Schildroth asked what the expectation is for regions to fund services for people who are on ID waiting list. Theresa Armstrong responded that regions would be expected to follow their own eligibility processes and service plans, and provide core services and other services included in the plan to anyone who is eligible. Iowa Code includes a provision that addresses such a situation. The region would look at what the person would qualify for through the region, and some of those services might be provided through the Waiver if the person had access to a waiver slot. Regions would have some responsibility to provide core services, but not everyone on the waiting list may qualify.

Deb Schildroth read from a Code section related to core services (331.397): "Within funds available, the region shall pay for such services for eligible persons when payment through the medical assistance program or another third party payer is not available unless the person is on a waiting list for such payment." She said that provision indicates to her that regions are not obligated to pay for services to people on the waiver waiting list, although they might choose to because they felt it was the right thing to do. It is a concern to regions because it could divert funds that are needed elsewhere to build service capacity. Theresa Armstrong added that services might also

be available through the Medicaid State Plan, although they would not be the specific HCBS waiver services.

Marissa Eyanson asked about the source of the 13% cost increase for the ID Waiver. Deb Johnson responded that it was not due to a specific item, but rather a combination of things including rate increases, staffing ratios, and other factors. Suzanne Watson commented that she has noticed an increase in expenditures since the CPC has been taken out of the process because they did a lot to negotiate rates and try to control costs. Deb Johnson added that the waiver program does a lot of good and there are some wonderful stories from people using the MFP program to start new lives in the community.

Deb Schildroth suggested inviting Deb Johnson back to talk about the implementation of CMS Home and Community Based Rules at a future meeting.

#### NEXT MEETING

The next meeting of the MHDS Commission is scheduled for February 19 at the United Way Conference Center.

Teresa Bomhoff said she has requested some information from IME:

- Information on the number of people who have not met IHAWP healthy behaviors requirements and will be expected to pay premiums
- Number of people are being dropped from health insurance coverage because they are not making premium payments
- Update on RFP for non-emergency medical transportation
- Prior authorization for anti-psychotic medications
- Outreach for IHAWP enrollment

Kathy Johnson suggested that at some future meeting, the Commission have an update on what regions are doing to develop and offer crisis services. Suzanne Watson said that she expects some of that information will be gathered over the next few months. Kathy also suggested inviting someone to provide an update on the SIM planning grant activities.

Kyle Carlson said he could address the question raised earlier about the FMAP for IHHs. The initial two-year period of 90% federal match for Phase 1 90% ends June 30, 2015. The enhanced match rate for Phase 2 ends April 1, 2016. The legislature would need to fund the difference when the match drops to the regular FMAP rate after those dates. The estimated cost for the first year is about \$7 million, which has been factored into the Medicaid budget. All three phases would be aligned at the regular FMAP beginning July 1, 2016.

Deb Schildroth shared some comments. She said there has been some talk about using the dollars that have been collected so far from Medicaid offset, about \$10 million,

to help with the shortfalls within the IHAWP, rather than going back out to the regions to help with services. There would have to be legislative action for that to happen.

Deb also said that Story County has now received bids from two private providers to take over all the service programs that were formerly part of Story County Community Life. The services include three 8-bed group homes, supported community living, day habilitation, and jail diversion programs. A recommendation will be made to the governing board and the board of supervisors later this month and contract negotiations will begin to make that transition. There is also a separate regional contract with a new supported employment provider, Progress Industries. They are starting to transition about 60 clients to its services this month.

#### PUBLIC COMMENTS

No public comments were offered.

The meeting was adjourned at 12:50 p.m.

Minutes respectfully submitted by Connie B. Fanselow.