Iowa HCBS Settings Transition Plan Public Comments
February 1, 2016 – March 2, 2016

Process:
Public comment on the HCBS settings transition plan (STP) was taken from February 1, 2016 through March 2, 2016. The STP was posted on the DHS website and was also available for review at each of the DHS county offices throughout the state for persons without internet access or other means to review the transition plan. An attachment to the transition plan (Appendix A) listing all specific HCBS settings that includes the provider name, city, type of residence (apartment, home, RCF/ID etc.) and service type (residential or non-residential) was also posted for review. The public was invited to submit comments through the dedicated email address HCBSsettings@dhs.state.ia.us or in writing to the Iowa Medicaid Enterprise.

Notification of the public comment period was released January 22, 2016, through informational letter No. 1605 sent to all HCBS waiver providers, case managers and DHS social workers. All major newspapers in Iowa published the public notice on or before January 24, 2016. Tribal notice was issued January 16, 2016. In addition to the announcement on the website, the department directly contacted provider organizations and consumer advocacy organizations to inform them of the public comment period and stakeholder forums. Organizations contacted include: Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, and ASK Resource Center.

Summary of Comments:
The department is taking a multifaceted approach to assessment of HCBS settings. This includes a systemic review of the State's rules and policies and a high-level settings analysis. Other avenues for assessment will include evaluating settings through the existing HCBS quality assurance provider self-assessment process and onsite review process; onsite assessments by community-based case managers; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences.

The assessment process is the starting point for further evaluation of residential and non-residential HCBS settings for compliance with the HCBS setting final rule. Once the assessment process is complete, each setting type will be identified as a setting that is either compliant with the HCBS characteristics, will be or is expected to comply with the submission of additional information, or a setting that will require a heightened scrutiny review.

The department contracts for the HCBS Quality Oversight Unit (QOU) function through a request for proposal process. The HCBS QOU is the single entity that is responsible for quality oversight of the HCBS setting implementation. While there may be multiple

entities that will be responsible for gathering data, such as community based case managers, the HCBS QOU is responsible for quality assurance activities for the department. Currently the department contracts with Telligen, Inc. to conduct the quality oversight of the HCBS and Habilitation programs.

The HCBS QOU uses a quality oversight process of discovery, remediation and improvement to assure compliance with all rules of the HCBS and Habilitation programs. When a compliance issue is identified, the provider is required to develop a corrective action plan (CAP) to address the issue. The CAP is submitted to the HCBS QOU for review and acceptance. Once a plan is accepted, a compliance review is scheduled and conducted within 60 days to assure that the activities identified in the CAP are being implemented. Providers that demonstrate compliance will be identified as such and ongoing quality monitoring activities are implemented for continued compliance. Providers unable to develop and implement an acceptable CAP to address the specific issues may have sanctions imposed up to and including termination from the Medicaid program. Any adverse action taken by the HCBS QOU may be appealed by a provider.

For HCBS settings, the various assessment processes identified in the STP are methods of discovery. The final outcome of the assessment and review process of HCBS settings is to determine whether a specific setting meets the HCBS settings rule. During the HCBS settings review process, if a provider is found to be out of compliance with the rules, the HCBS Quality Oversight Unit will work with the provider to develop a CAP to come into compliance. Once a plan is accepted, a compliance review is scheduled and conducted to assure that the activities identified in the CAP are being implemented. Providers that demonstrate compliance with the settings rules will be identified and ongoing quality monitoring activities are implemented for continued compliance. If the plan is either not accepted or a compliance review finds that a provider has not implemented the approved plan, the provider will be notified that HCBS funding is not available to waiver recipients receiving services in that location. This does not mean that services cannot be provided in that location, but rather that HCBS funding is not available to members to fund services at that locations.

When service locations are found to be out of compliance with the rules and are unable to become compliant through a CAP, the department believes that most members will secure a new provider in a location that meets the settings standards or will find alternative HCBS services in integrated settings to meet their needs. But as noted in some of the comments received on the STP, there may be some members that like the services they are receiving and will want to continue to receive services in the non-compliant location. One of the foundations of person centered planning is member choice of providers and services received. A member may choose to receive services in non-compliant settings, but HCBS funding will not be available.

Unless the site specific setting is a hospital or medical institution that does not meet setting criteria, the experience of the member receiving services in that location is the primary defining element of the HCBS final rule.

Full Comments and Responses

Persons submitting comments:

Sara Miner, Linnhaven, Inc. (email)
Shirley Boswell (email)
Jane Hudson, Disability Rights Iowa (email)
Robyn Landon, Case Management Supervisor (email)
Shelly Chandler, Iowa Association of Community Providers (email)
Harry Jacoby, Access, Inc. (email)
Catherine Gray, provider
Cindy Baddeloo, Iowa Health Care Association
Derek Laney, FOCUS – Family Options & Community Supports, Inc.
June Klein-Bacon, Olmstead Consumer Taskforce
Matt Blake, LeadingAge Iowa (email)

SPECIFIC COMMENTS AND RESPONSE

COMMENT:

One of the most cumbersome rulings of recent years was the restriction on HCBS consumers in an office area during direct-support for budgeting/bill-paying. For many providers the dual roles of provider and payee are conflicted.

HCBS correctly requires providers to work directly with consumers on their finance goals in community integrated settings. You'll get no argument from me on that. However Social Security requires that critical account information -- including checkbooks and bank cards-- be secured against consumer access.

While I strongly support rulings that ensure community services be provided as intended by advocates and administrations alike, when it comes to payee services there is a dual role providers fill that I believe mitigates the issue. The distinction between payee and provider roles is highlighted by the fact IME does not fund or regulate the former. And in such cases, the service provider's office becomes a *de facto* community support location, same as one would consider the office of any other payee -- e.g., a bank or attorney's office. Simply put, the office or other secure spot becomes the location where a separate non-IME service is provided.

I know this issue has been raised and ruled on before. But with so much in transition, I hoped to get it a second hearing. Among providers who also serve as representative payees, the problems of dual expectations are very difficult.

RESPONSE:
Thanks for the comment. You are correct that this issue has been raised before and the department believes the HCBS setting rules supports the departments' position against the use of provider office space for service provision.

COMMENT:

1. Iowa HCBS Settings Statewide Transition Plan – Institutional Settings and Heightened Scrutiny

LAI (LeadingAge Iowa) is concerned about the continuation of HCBS services in settings that may be deemed adjacent or connected to a building that is institutional in nature. LAI members provide elder care services for the entire continuum of care. Many of these providers have multiple levels of senior care located on one contiguous campus. The transition plan, as written, may narrow the availability of HCBS services across Iowa if current settings criteria are not clarified.

HCBS providers with services located in assisted living (AL) facilities or adult day services can be positioned on the same campus or connected with a nursing facility or other entity institutional in nature. Currently the federal recommendations indicate that a HCBS service provider that is located on the same campus, connected to a nursing facility, or other entity institutional in nature, must have distinct separate entrances and signs for each service. This limited instruction from CMS in conjunction with the integration into a broader community leaves many providers confused on how their HCBS service program will be affected by the settings rule. The DHS transition plan does not fully address this concern.

How does DHS plan to interpret HCBS settings guidelines for HCBS service providers located adjacent or connected to an entity that is institutional in nature? Will it simply require different entrances or require further separation? Separate staff? Separate food preparation? Separate billing? Further, the rule as written may keep several HCBS providers from serving Medicaid members through the waiver. HCBS providers who house Medicaid members in AL facilities connected to a nursing facility or have adult day services on the same campus with a nursing facility would lose the ability to provide services to these lower income Iowans. LAI does not believe the intent of the rule is to restrict the number of providers via the setting, but open up members to a wider range of community experiences. In a time when Medicaid managed care is looking to move people from institutional care and into HCBS waiver programs, restricting the ability of providers to offer these services will be detrimental to the intent of managed care.

LAI understands that DHS does not have the ability to deviate far from the rules set forth by CMS. Additionally, we understand that the limited information provided by CMS keeps DHS from making significant policy declarations. However, if the federal government is unable to provide further guidance, it is up to DHS to clarify rules to HCBS providers. Before HCBS providers enter into the heightened scrutiny process, it would be better if the HCBS providers have additional factors to help prepare their facilities or settings to meet the HCBS settings rule. Other than separate entrances, what can providers do to avoid the heightened scrutiny process and continue to provide services to Iowa's vulnerable population?

Finally, in the DHS transition plan, it states DHS will be using addresses of institutional facilities and HCBS service providers to help determine whether a setting is located in proximity to an institution. As stated, in the Q & A about the HCBS settings rule, CMS says, "The regulation requires that all settings, including facility- or site-based settings,

must demonstrate the qualities of HCB settings, ensure the individual's experience is HCB and not institutional in nature, and does not isolate the individual from the broader community." Simply using an address as the indication of whether a setting may be institutional in nature does not reflect the intent of CMS. As outlined in the "Exploratory Questions to Assist States in Assessment of Non-Residential Settings," CMS has an extensive list of qualities that make a non-residential setting compliant with CMS regulations. LAI does not believe that a HCBS program sharing an address with a nursing facility is a fair measure of compliance. As stated, many LAI providers have communities that house the entire elder care continuum on one campus. Having different addresses for each respective service they provide would be onerous and inefficient. We understand the intent of the measure is to explore potential settings that may be institutional in nature, but the process seems to trigger the heightened scrutiny process before individual assessments of the facility are made. LAI recommends clarifying the language to indicate that the address process is simply to find potential settings and the heightened scrutiny process is only initiated after onsite review has found issue with the setting. Heighted scrutiny should not be started simply due to proximity.

2. Settings that Isolate. The state has some mechanisms to find settings that isolate, but it is an incomplete plan because it only relies on geographic proximity factors.

3. In section 2.3.4.1- Heightened Scrutiny: Can you clarify, that if an Assisted Living providers is a free-standing provider (not associated with a NF, ICF/DD, or other institution), it would not be automatically considered under "heightened scrutiny". We don't believe, just because a program is licensed as an Assisted Living program, that it would fall under heightened scrutiny.

4. *Section 2.3.4.1 Heightened Scrutiny*

The STP describes what settings are presumed to be institutional in nature, but does not identify these settings. By June 30, 2016, the state will have collected data on which settings may be subject to heightened scrutiny. By December 31, 2016, the state will have evaluated this data and identified which locations may be subject to heightened scrutiny. The state has developed a geo-data matching process for determining this which is to be completed by 6/30/16. The state indicates that, by 12/31/16, it will have identified, through the data matching process and on-site assessments, any settings which may be subject to heightened scrutiny. However, the state will not update its transition plan until 6/30/18, almost a year and a half later. Providers, HCBS recipients and their families need to know much sooner about which settings may be subject to heightened scrutiny determinations. Both the 6/30/16 and 6/30/18 update need to provide specific information about which settings will be subject to heightened scrutiny and which settings do not have qualities of HCBS and cannot be remediated.

The state indicates it plans to submit to heightened scrutiny the compliance plans, but it is not clear that this is allowed and it would seem very unwise to allow a setting that is already assumed to have institutional characteristics to pass heightened scrutiny on a promise.

RESPONSE:
States have an obligation to identify settings that are presumed institutional. The site specific assessment process is identified in section 2.3.4 of the transition plan and incorporates multiple approaches that will be used to assess and classify residential and non-residential settings. Geographic proximity and licensing considerations are only starting points for determining whether a setting may be presumed institutional. Those settings presumed to have institutional qualities must have a higher level of review, or heightened scrutiny, to determine whether they have the qualities of HCBS or that of an institution. The heightened scrutiny review determination will be made after the IME HCBS Quality Oversight Unit completes a review of the location using criteria in #8, #9, and #12 in section 2.3.4 of the transition plan. Providers will be notified of the status of the setting and the review process to be used prior to the provider's setting review.

COMMENT:
1. Iowa HCBS Settings Statewide Transition Plan – Isolating Individuals and Community Integration
LAI requests specific guidelines to help providers meet compliance standards in regards to settings that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. Many providers of AL, adult day, and other services have indicated they find the current guidance related to these requirements insufficient. The questions boil down to "what is enough community integration?"

LAI members are finding the standards set forth in federal guidelines too broad and general to implement coherent compliance protocol. HCBS providers, especially AL and adult day programs, request further guidance from DHS on how a surveyor will determine whether a particular setting meets federal requirements. Providers are worried that if the guidelines are too general and lack specific obtainable goals, there may be a wide variance in survey results between different HCBS settings and, regardless of changes to provider protocol, it will never be enough to fully integrate their Medicaid members into the community.

2. Is there a form or audit tool, that DHS and the MCO will be using for the onsite setting analysis? We ask that the audit tool, be made available to all HCBS providers?

RESPONSE:
The HCBS Provider Quality Management Self-Assessment is the tool used by the IME HCBS Quality Oversight Unit for use with providers to assure compliance with HCBS rules. The 2014 self-assessment was used to gather initial information from providers

on the CMS final rules on settings. The 2015 self-assessment was modified to further reflect the final rule. See informational letter No. 1556.

The self-assessment is used by the IME HCBS Quality Oversight Unit in all areas of provider quality oversight and is used by providers to identify the policies and procedures that are in place to support compliance with the rules of the waiver program. Section III. B of the self-assessment identifies the criteria that will be reviewed. Provider must have evidence to support the policies and procedures that they identify in support of community integration. The criteria reflect the exploratory question issued by CMS to assist states in the assessment of residential and non-residential settings. The self-assessment can be found on the IME website at: http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment.

COMMENT:
Iowa HCBS Settings Statewide Transition Plan – Choice of Services
LAI is concerned with language in the transition plan regarding choice of services. On page one of the transition plan DHS states, "the regulations also aim to ensure that individuals have a free choice of where they live and *who provides services* to them" (emphasis added). LAI is asking for further clarification from DHS on how it intends to interpret this guideline. We are concerned this language may interfere with how care is provided in AL settings, and other settings where Medicaid members live and receive services from a HCBS provider. If the above language is read broadly, it would indicate that Medicaid members would have the freedom to choose to live in the AL facility and seek services from a provider other than the AL provider. If this is the interpretation DHS will follow in implementation of the transition plan, LAI believes many AL providers will find it difficult to continue to house Medicaid members if they cannot provide their own services onsite. While LAI believes this is likely not how DHS will interpret the language, LAI seeks definitive clarification from DHS.

RESPONSE:
The HCBS waiver programs pays for needed services to support a member to remain living in the home and community setting of their choice. Waivers do not pay housing and living expenses of the member. Members are afforded choice of who will provide services through the person centered planning process and authorization of service in their services plan.

CMS has clarified that members are making a choice when receiving services in provider owned or controlled settings. The final rule clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers

the service separate from the bundle. The specifics of the service provision is identified in the service contract between the member the provider.

COMMENT:
Iowa HCBS Settings Statewide Transition Plan – Food Service
Currently in 481-69.28(231C) and 70.28(231D), the administrative rules related to food service in AL and adult day services, respectively, there is no language indicating that residents of AL or adult day are allowed to have access to food at any time. LAI does not find that residents having access to food to be a burden to providers, but further clarification is needed in Iowa Administrative Code (IAC). In the 2.3.2: Systemic Assessment: Setting Analysis, DHS indicates the regulations for AL fully comply with the CMS settings regulation. We disagree. LAI requests further clarification on food services for residents in AL. Does access to food require food preparation appliances, such as a stove or microwave, in each room? Does access to food simply mean storage capacity in a resident's room to allow for storage of food? Does access to food mean that AL food preparation needs to be ready at the resident's convenience? LAI recommends further guidance to HCBS providers on how access to food should be handled in AL and adult day facilities.

RESPONSE:
With the final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in the final rules establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The outcome when looking at Assisted Living locations is the same as a person living in their own home or provider owned and controlled location; that the member controls his/her own schedule including access to food at any time. Assisted living providers have many ways to meet these criteria and should establish policies and procedures to address member access to food. The current provider self-assessment review process requires a provider to document and submit evidence to support the way it implements their policies and procedures.

COMMENT:
Iowa HCBS Settings Statewide Transition Plan – Lockable Doors and Control of Schedule
1. Many AL facilities follow the process outlined in the new settings rule for lockable doors. Allowing appropriate staff to have keys to a resident's room is standard practice with any HCBS providers. However, we seek further clarification in IAC on how closely the standard will be followed.

In the case of specific patients, such as a dementia resident, can facilities deviate from the rule to provide for a resident's safety? The same example can be used for the freedom to control Medicaid member's own schedule. Can individual freedoms be curtailed to prevent wandering, injury from equipment, etc.? CMS states in the federal comments that § 441.301(c)(2)(vi) will allow for deviation if it is supported in the person-

centered service plan. LAI asks that IAC reflect these changes to allow for some deviation if the safety or wellbeing of the resident may be compromised by the settings rule and is supported by the person-centered service plan. We particularly want these changes reflected in IAC for sections where the residential setting is owned or controlled by a service provider or a non-residential setting.

2. Lockable Unit (p. 2) The summary of the lockable unit requirement is either slightly wrong or could easily be misinterpreted by the reader. It says that each individual has privacy in their sleeping or living unit and that this includes having entrance doors which can be locked by the individual with only appropriate staff having keys. It is not clear that this means entrance unit to the sleeping unit and the "only appropriate staff having keys" is not actually quite correct under the rule as this right can only be restricted through the person centered planning process, not just a general allowance that appropriate staff can have keys and possibly enter at any time.

RESPONSE:
Members have the right to dignity and privacy within their home which may include having lockable doors and access to all areas of their home. Any right restriction that may be needed for the health and safety of the member must be addressed by the team and agreed to by the member or their legal representative. Any right restriction requires that the restriction be identified in the member's person centered plan. The IAC does not need to be changed to address this concern.

As noted in comment 2. above, the STP will be modified to clarify the issue of locked doors.

COMMENT:
1. Iowa HCBS Settings Statewide Transition Plan – Onsite Inspection
LAI regards the DHS plan for allowing two different on site inspecting entities to be troublesome. As indicated in section nine of the Site-Specific Assessment Process in the transition plan, DHS will be utilizing the MCO case managers for onsite reviews of residential HCBS providers, and leave non-residential review to the HCBS Quality Oversight Unit. While we understand the need to streamline efficiencies in reviewing HCBS settings, we find a split in oversight capacity worrisome. While there will be training to prepare MCO case managers to review the quality of residential HCBS settings, we find that two different reviewing agencies will create discrepancies in the review process. There may be wide variance in the review process with all three MCOs having different managers in the field with varying levels of experience. We would recommend placing all assessments under one entity, specifically DHS.

2. With the delegation of some of the onsite assessments to the MCO case managers, are there steps being taken to ensure no duplication or discrepancies with the HCBS Quality Oversight Unit? Who would the provider appeal the decisions to DHS or the MCO?

3. Page 29 #7, Page 30 #9 – Case Managers as Provider Assessors. Having individual MCO case managers assess settings will force providers to have settings assessed in triplicate. IACP recommends this function be left with a single state-designated entity. This will be dually beneficial as it will help to reduce cost overlap due to duplication and will allow case managers to focus on coordinating person-centered services rather than assessing providers and implementing corrective action plans.

4. Validation of Provider Self-Assessments. The validation process of the provider self- assessments should be conducted by an independent entity, rather than HCBS regional specialists or managed care case managers, because they may have a conflict of interest since they need services for their clients even if the services are non-compliant with the HCBS rules. In addition, the plan does not offer much information about how the HCBS qualities are being incorporated into the existing validation and quality assurance process. This should be explained more fully.

5. Does DHS maintain the final decision on the compliance review decisions and corrective action plans, or is this delegated to the MCOs for specific providers?

RESPONSE:
The IME contracts with Telligen Inc., to conduct provider quality oversight activities conducted by the HCBS Quality Oversight Unit. This unit provides independent oversight of the services provided by HCBS and Habilitation providers.

MCO and fee-for–service case management regulations require a case manager to have contact with a member on a monthly basis and must include a face-to-face meeting in the member's home at least quarterly. Since case managers will be in the home at least quarterly, the IME has determined that the case manager is an appropriate entity to evaluate the members residential setting for compliance for integrated settings. The IME will develop and train CMs to use a standardized tool. The Community Based Case managers will not have a role in remediating non-compliance issues with providers. All assessment data gathered by the CBCM will be submitted to the HCBS Quality Oversight Unit for review, analysis and follow up with providers and case managers as needed.

COMMENT:
Iowa HCBS Settings Statewide Transition Plan – Appeals Process
What may be clarified in yet-to-be-released administrative rules, there is no defined appeals process outlined in the transition plan. As currently written, there is no recourse for providers to challenge the reviews done by the onsite inspections by either the MCO or DHS. While we assume that the appeals will follow the Informal Dispute Resolution (IDR) and subsequent appeals process currently in place for annual onsite surveys of nursing facilities and HCBS providers, LAI seeks clarification on whether this assumption is correct or a new process for challenging inspections will take place.

RESPONSE:

Providers have the right to file an appeal if they disagree with a decision made by the department which includes actions by the HCBS Quality Oversight Unit. Iowa Administrative Code 441 Chapter 7 identifies the process. Information about the appeal process is found on the DHS website: http://dhs.iowa.gov/appeals. This information will be added to the transition plan.

COMMENT:
Iowa HCBS Settings Statewide Transition Plan – Conclusion
LAI fears that if the transition plan goes forward as written, there may be LAI providers offering HCBS services who will be forced to stop services due to the settings rule. Depending on how stringent the guidelines are interpreted, many providers who offer HCBS may either be forced to suspend services due to the location of the HCBS program or discontinue HCBS services if the regulations become too burdensome. We know it is not the state's desire to limit lower cost living options or services to Iowa's vulnerable and elderly populations. LAI hopes DHS will accept the recommendations and requests for clarification outlined in this document to help with a seamless transition to the HCBS settings rule without hurting services to Medicaid members.

RESPONSE:
The department appreciates the comments and will continue to work with all members, providers and others to assure full compliance with the final rule on HCBS Settings.

COMMENT:
Can NFs & ICF/IDs provide any HCBS services such as respite and home delivered meals to persons on the HCBS waivers, since they are considered an institutional setting?

RESPONSE:
Any provider that meets the HCBS Waiver services provider enrollment criteria in IAC 441 Chapter 77 may provide the services. In the subregulatory guidance published with the final settings regulation, CMS clarified that HCBS institutional respite is permitted to be delivered in an ICF/ID. Home-delivered meals is a service that is provided in the member's own home and is considered compliant, even when the meal originates in an institutional setting such as a NF.

COMMENT:
Why are the rates for my hourly and daily being set, off the cost reports from 2 years ago??? You guys don't get your wages based upon cost of living or inflation from 2 years ago; so why should I have to be subjected to this haneous atrocity way of computation as an HCBS provider ?????

This is unfair to me and my son. His goals and objectives aren't set forth for the coming year based upon his past achievements from 2 years ago….why do you people insist

upon belittling us providers and not allowing us the same current rates that YOU all receive as employees?

How would you like to receive your wages based upon what people made 2 years ago?

This is NOT how you treat providers who support and manage society's most vulnerable in oftentimes doing a job that MOST people would refuse to perform, and in many cases is VERY draining both emotionally and physically!

Some of you really have NO CLUE whatsoever the grueling daily tasks that is required of us!

RESPONSE:
Your comments do not directly address the information in the STP. You may want to address your concerns with the Iowa Medicaid Enterprise or with you elected state representative.

COMMENT:
1. Many providers are still unsure of how setting requirements will apply to group homes that are in the community with "members" totally satisfied with their community access and involvement. Some of the members are medically fragile and do very well living with their friends in a 12 bed group home. If all of these group homes are found to be isolated or segregated, some of the members will most likely be transitioned to nursing homes which are more isolated and segregated and the members will lose their way of life and friends. I have been told that subjectivity will be involved and my hope is that the member and their families will have some say rather than be told that the building does not meet standards. I also have concerns about Day Habilitation programs being expected to provide services out of buildings for most of the day. As many prominent experts in the field have commented that being in the community most of every day is not anywhere near normal. We should work to get members involved in the community as members without disabilities, but not to go to excess and extremes because there is a disability…..

….In summary I think the results will be as follows:

- Smaller providers will go out of business and larger providers will provide cookie cutter services – I have seen this in the past and the true quality to the person served decreases, but excellent paper work is produced.
- Members will not be as happy in their new apartments and will miss friendships developed over years, but they will be doing what we want them to do and that is what matters to regulators.
- Some will die as a result of movement from a medically, well staffed facility to apartments with an SCL worker – this has already happened (Oklahoma, etc.) and will continue.

- Members who developed or at least maintained skills in Day Habilitation programs will have days cut and will look out the windows of the apartments – this has already happened and will continue to increase.
- Members in Prevocational services will be forced out of this service some of which are waiting for job coaches to find a community job. This service will end and there will be no workshops in the future as everyone must receive minimum wage.
- We will see groups of members wandering around malls and parks during the day – day after day – rather than be in a building and that will meet requirements rather than what they really want to do.
- We will see more cuts in Medicaid funding as the HCBS rules will increase costs – but with private for-profit managed care companies now in 39 states it will only get worse as time goes on.

Eventually people will really listen to people with disabilities and their families and we will have to put many things back in place. We will realize that the system we had was pretty good, but lacked job placement, supported employment, more member pay for work performed, and better pay for DSPs. We are throwing the baby out with the bathwater and the people who think they know what is best for everyone really don't. One size does not fit all and HCBS rules do not fit all.

2. I would like to make some comments and/or concerns regarding the proposed settings transition.

Most of the individuals that reside in 24 hour care "waiver homes" do so for many positive reasons including: 1- sharing housing costs on a fixed SS budget, 2- safety issues where the individuals need to be supervised 24 hours/day (unable to effectively respond to emergencies, avoid exploitation of finances, avoid exploitation of self "freely engaging in sex acts when asked, unable to say no), 3- sharing of waiver staff (to reduce costs of services, instead of 1:1 services which would ultimately cost the state more money).

Many of the individuals we work with receive the minimum $790?/mo SSI which is not a lot of money to rent their own private unit, pay utilities, food, transportation, etc…)

Our area has no HUD funding right now and waiver rent subsidy has been sporadic if funds available.

We also do not have enough low income housing in our area to support most of the individuals having their own private unit. We fear this would promote individuals to live with family members who may NOT be good supports and would take advantage of them.

3. There is a reason why sometimes our people end up pooled together in an area or apartment complex. It is because they are on a fixed income and have to live where they can afford to pay the rent. Yet, our individuals are not allowed to save money past $2000.00 resulting in many of them being forced into lower income housing and thus living around other individuals with disabilities because that is all they can afford, too! It's not fair to try and force them to move and or separate when they simply don't have the means to live elsewhere. I feel for the most part, our members are doing the best they can, already. If they could live someplace better or more separated, they would probably already be living there. I feel we need to think this through more before making things worse for our members. We need to set them up for success not failure.

RESPONSE:
With the final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in the final rules establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The outcomes when looking a 12 bed facility is the same as a person living in their own home or smaller provider owned and controlled locations; that the member has access to and is integrated into the greater community the same as those persons not receiving HCB S services. Residential service providers have a variety of ways to meet these criteria and should establish policies and procedures to address the HCBS setting guidelines.

COMMENT:
1. Engagement of Stakeholders and Public. The Taskforce recommends that the state address plans for information sharing, transparency, and public engagement from this point forward on the work being done to monitor and ensure compliance with the final rule by the March 2019 deadline. The state should plan for and detail how it will communicate progress made towards the benchmarks outlined in the plan.

2. Results of Assessments to Date. STP Appendix A ("Iowa HCBS Settings Based on 2014 Provider Self-Assessment," should include a column regarding the current level of the compliance of specific HCBS settings with the HCBS Settings Rule.

RESPONSE:
Information, news and announcements have been made available on the HCBS Settings Transition page on the DHS webpage: http://dhs.iowa.gov/ime/about/initiatives/HCBS. The STP will be updated to include the information that will be posted to this website. The plan will be updated to identify and include more opportunity for feedback from stakeholders.

COMMENT:
Managed Care Organizations. The plan acknowledges that training will be provided to community-based case managers employed by the state's contracted

managed care organizations (MCOs) on the federal settings regulation, Iowa's statewide transition plan, and the specific tools and processes they will use in conducting onsite assessments. MCOs have, to date, been largely silent on *Olmstead* compliance and HCBS settings compliance and monitoring. We underscore the importance of ensuring the training provided is robust, particularly because the selected MCOs do not have extensive experience in the area of long term services and supports. The Taskforce recommends more communication about what the training process will include, and encourages the state to incorporate education about the *Olmstead* decision and Iowa's work towards compliance with the integration mandate.

Additionally, the *Onsite Assessment by MCO Community-Based Case Managers* in section *2.3.*4 of the plan (p. 30) should be edited to reflect the fact that Iowa has reduced the number of MCO contracts from four to three.

RESPONSE:
The Department agrees that training will be important during the transition and ongoing operations of waiver services managed by the MCOs. All training materials will be reviewed and approved by the IME prior to use to assure that it is fulsome and includes all required information. Any assistance from the Taskforce around training MCO on Olmstead would be appreciated. And thanks for catching the MCO error. The STP will be amended to reflect the accurate number MCOs operating in Iowa.

COMMENT:
1. Access to the Community. Iowa's plan is heavily weighted towards addressing residential services and supports. This is misaligned with the CMS emphasis on access to the community, including opportunities to seek employment and work in competitive, integrated settings. It is imperative that the staff involved with implementing and monitoring the rules understand this and apply them to all aspects of access to the greater community. Additionally, in order for this protected class of individuals to truly be able to engage with the community of their choice to the same degree as those who do not receive waiver services, the Department must demonstrate a prioritization on building community capacity.

2. Competitive Integrated Employment. The preliminary Provider Self-Assessment questions need to separate residential and non-residential services, such as habilitation and employment services, to get a true picture of whether non-residential settings are complying with the HCBS settings rules. The STP needs to contain a full discussion of how DHS will assess, validate and transition individuals receiving waiver and habilitation services from segregated non-residential services to services that comply with the HCBS Settings Rule.

RESPONSE:
The HCBS setting final rule is applicable to all settings, both residential and non-residential. The STP will assure the assessment of service provision in all settings where HCBS services are provided.

COMMENT:
Waiver Waitlists. The Department must plan for and demonstrate measurable progress towards reducing the HCBS waiver waitlists. Regardless of how diligently DHS works to comply with the settings rule, the efforts will be unsuccessful as long as there are thousands of Iowans on waitlists for services. The state is in a unique position at this moment to build on the foundation set by the final rule and the state's shift of Medicaid to managed care. Now is the time to push for funding, creative problem solving, and the leveraging of resources the three selected MCOs have to ensure access to vital home and community-based services for all who qualify.

RESPONSE:
Thanks for the comments. The department will continue efforts to work to reduce the number of persons waiting for a funding slot for waiver services.

COMMENT:
Brain Injury Waiver Services. Section *2.2: HCBS Program Included in the Transition Plan* references an upper age limit of 65 for brain injury waiver eligibility. This should be corrected to reflect the HCBS administrative rules change that went into effect July 1, 2014 removing the age cap.

RESPONSE:
Thanks for catching the BI age limit error. The STP will be amended to make this change

COMMENT:
Assistive Devices and Environmental Modifications. Currently, as outlined in section *2.3.2: Systemic Assessment: Settings Analysis*, assistive devices are only available under the elderly waiver, and environmental modifications are only available under the children's mental health waiver. We would like to see assistive devices and environmental modifications covered by all waivers, as both areas greatly support a person's ability to live, work, and recreate in the community.

RESPONSE:
Thanks for the comment. The addition of new services to any HCBS waiver will have a fiscal impact on the overall cost of the waiver programs that would require additional funding appropriated by the Iowa Legislature. Advocates are encouraged to contact their elected officials if they have concerns.

That being said, the April 1, 2016, change to IA Health Link and management of HCBS waiver services by MCOs offers opportunity for members in getting unmet needs met. A MCO may offer "value added" services that cover benefits beyond regular Medicaid coverage. Some MCOs include assistive devices and durable medical equipment as value added services. Members are encouraged to review the benefits and services offered through each MCO when selecting a MCO.

COMMENT:
IACP requests that the Department take the following actions:

1. Provider Sanctions, Page 37 #6. Recommend changing start date for sanctions to 3/18/2018. CMS has allowed states a 5-year period to come into compliance with the settings standards. Moving the date for possible sanctions of providers to one year prior to the federal deadline will allow the state enough time to address noncompliant settings while reducing the risk of provider sanctions.

2. Corrective Action Plans. Provider's corrective action plans should be available to service recipients, families, guardians and advocates so that they can make informed decisions about their services. In addition, the provider should include milestone dates in the CAPs and the state should be evaluating CAPs on a timeline similar to the timeline of the Department of Inspections and Appeals, rather than through the standard quality review process schedule, which may be one-three years, and as long as five years.

3. Provider Assessment Findings (p. 36, #2). The STP indicates that the state will present each provider with the results of the assessment of their HCBS findings as findings occur throughout the assessment process. This information should also be shared with waiver and habilitation service recipients, their families or guardians, advocates and other members of the public so that they can make informed decisions about where to receive services.

4. Compliance Reviews (p. 36, #4). The STP states that compliance reviews will follow the normal HCBS quality assurance review cycle, which could be one 'to three years, and as long as five years. If a provider is non-compliant, the compliance review with the corrective action plan should contain annual milestones for each stage of the remediation process and DHS should review on a yearly basis whether the milestones have been reached.

RESPONSE:
Comment is duly noted. The state will present each provider with the results of an assessment by June 30, 2018 and, as needed, work with the provider to develop a corrective action plan to address the non-compliance issue(s). CAP development and the compliance reviews will be conducted through December 31, 2018. This timeline will assure that all settings that require a CAP will have the time needed to come into compliance prior to March 17, 2019.

All reports that are generated as part of any HCBS provider review are available upon request.

COMMENT:

Provider-Controlled Settings, Page 19. When discussing provider-controlled settings, we recommend striking language regarding provider "24-hour" presence. This definition of provider-controlled runs the risk of inadvertently, and inappropriately, including places that should not be included in cases where members own their own homes or rent from private landlords. In addition, we believe it leads to confusion when provider staff provide daily services but are not present in the person's home 24 hours per day.

RESPONSE:
CMS has clarified:

> "If the individual leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled. If the HCBS provider leases from a third party or owns the property, this would be considered provider owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, we would presume that the setting was provider controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants".

The department agrees and will make changes to the STP based on your comments.

COMMENT:
I am the mother/legal guardian of our 25 year old daughter who has Down Syndrome. She has been receiving services from (PROVIDER NAME) for the past 4 years. Initially she lived at home and commuted the 40 miles to (PROVIDER NAME). Three years ago she moved into a waiver house in Atlantic. She spent her days at (PROVIDER NAME) where she worked on the work floor for part of her day and then was in Day Hab where she socialized with her peers. Life was good! (MEMBER NAME) enjoyed working and (PROVIDER NAME) was very good at challenging her in the afternoons with activities where they had a weekly theme to learn and study (ex. Presidents –for Presidents Day). She had a daily journal that she read to her peers and shared her activities. She had access to computers and exercise equipment. They had outings into the community where they might enjoy a picnic at a park or visit the county fair. Life was good! (MEMBER NAME) was happy and we were happy for her.

The past few months things have dramatically changed for (MEMBER NAME) and (PROVIDER NAME). (PROVIDER NAME) is trying to prepare for the new requirements that our children not be isolated from the broader community. However, the opposite is happening. She is more isolated now than ever before and it is going to get even worse. (PROVIDER NAME) has closed the Day Hab part of their program. (MEMBER NAME) now after working at the work shop goes to her house at 12:30 pm. It is my understanding that her work shop will also be closing. So where she once had a day of meaningful activities with peers will soon be a day at home. Sure there will be staff to

plan outings but not to the extent of what she once had. When you live In a small town there is only so many places you can visit to qualify being in the broader community each day. Her previous schedule gave her a purpose and place to go each morning - just like those of us who are able to go to work or school each day.

I realize not all programs were of high quality as (PROVIDER NAME). Ideally, the idea of keeping our loved ones from being isolated from the regular community sounds great – on paper. I just want you to be aware of the consequences of what the new requirements are doing to my daughter and others like her out here in the real world.

RESPONSE:
Thank you for your comments. The IME will continue to work with providers, stakeholders and advocates to develop a service delivery system to assure the HCBS setting criteria is in place to support the needs of the members that are served.

COMMENT:
Iowa's HCBS Capacity. There is no mention of examining the current array of settings and needs of the HCBS population to ensure that at the end of the transition period the state can ensure that individuals are offered a non-disability specific setting during the person-centered planning process.

RESPONSE:
During the person centered planning process, the member and their interdisciplinary team review the individual needs of the member and identify local resources that may be used to meet the individual need.

COMMENT:
1. More inclusion of Medicaid members, their families and advocates in the assessment process. Except for outreach meetings in 2014, the STP makes almost no mention of Medicaid members, their families and guardians or advocates, and is focused almost solely on providers. This exclusion is contrary to the HCBS Settings Rule and has resulted in inaccurate indicators of home and community-based services being used.

2. Comments are accepted electronically through a dedicated email address, which is not a particularly accessible mechanism in terms of allowing the broadest audience possible to comment. The state offered to accept written comments to be submitted by mail or direct delivery to the IME office. These options are not particularly accessible. Not all individuals have ready access to the internet or have email accounts. In contrast, other states have taken public comment via phone or at listening sessions. Iowa should provide the same opportunities.

RESPONSE:

Duly noted. In addition to IPES interviews and the individual member setting review conducted by case managers, the state will seek additional opportunity for members, families and other stakeholders to have input in the assessment of settings. In regard to the public comment period for the STP, the state has met the federal requirements for providing notice and accepting comments both electronically and non-electronically. The state will review alternative options for public comment in the future.

COMMENT:
Section **2.1.1** Summary of Comments Received

DHS should not only summarize the comments received, but post all comments on the HCBS web page) for review by the public.

Add the following language: DHS will also post all comments on the STP on DHS' HCBS Settings Transition web page for public review.

RESPONSE:
The department agrees and will post all comments received on the DHS website.

COMMENT:
1. In its 9/4/15 letter, CMS required DHS to provide its methodology for conducting systemic assessment and findings of the administrative code. In the STP, DHS fails to provide information about:

a. who conducted the assessment (a lawyer from the Attorney General's Office or the Department of Human Services or Iowa Medicaid Enterprise(IME); a non-lawyer from DHS or IME
b. what methodology and criteria were used for determining whether a Code provision complied with the HCBS Settings Rules; and,
c. how the Code provision should be amended to bring it into compliance.

By failing to do so, it is impossible to determine how DHS/IME arrived at its conclusion that a regulation was compliant with the HCBS Settings Rules. For example, the STP states that the following code provision supports the HCBS Settings Rules:

> For 1915i Habilitation Services, home-based habilitation services, community inclusion is addressed in 441-78.27(7)"a" for day habilitation services in 441-78.27(8)"a".

DHS' determination that habilitation rule is in compliance with the HCBS Settings Rule is in error for several reasons:

1. The statement that community inclusion is "addressed" does not indicate whether the rule is in compliance with the HCBS Settings Rules and does not explain why the reviewer reached this conclusion.
2. The state says that the 1915(i) habilitation services rule "supports" the HCBS rules, when in fact this section cited refers to a person-centered planning section that is in conflict with the rules as the coordinator appears to be in charge of the process, "establishing an interdisciplinary team for the member" and with the interdisciplinary team the coordinator identifies the member's services based on the member's needs, the availability of services, and the member's choice of services and providers. There is nothing about the individual directing the services, the process seems to reflect that the people involved are chosen by the coordinator with no indication of even influence on these choices by the participant, no mention of supports for individual decision making, no conflict of interest provisions or problem solving, the "services available" language seems to potentially limit the service selection to what is currently available as opposed to all services in the waiver, e.g., being offered the choice of a non-disability specific setting and being put on a waitlist if necessary for such a setting. There is also nothing about choices being informed and supporting full access to the community, or other person centered planning requirements.
3. The rule allows day habilitation services to be provided in settings that are institutional (e.g. residential care facilities) and in settings that isolate individuals with mental illness from the community. Most day habilitation services are currently provided in segregated settings and the current rule would not prohibit this.
4. Iowa is transitioning from a fee-for-service Medicaid system to a managed care system on April 1, 2014. The current administrative rules describe the previous system rather than reflecting the changes that will occur when Iowa moves to managed care system.
5. In the survey and certification of administrative rules for facilities (p. 17), the STP indicates some changes that would need to occur in the rules, but also says that the Medicaid program cannot make changes to these rules. If the Medicaid program cannot make changes to the rules regarding facility certification and licensure, the Iowa Department of Inspections and Appeals should be involved in the STP process so the state can do more than recommend changes. These rules are critical as they are for the HCBS settings that are licensed as residential care facilities, assisted living facilities and adult day programs and include some concerning conflicts with the HCBS settings rules.

Since the analysis of these Code provisions is not in compliance with the HCBS Settings Rules and do not reflect Iowa's move to managed care on April1, 2016, the analyses of other code provisions are suspect as well. The STP states that new rules are currently under review with the AG's office and will begin the rulemaking process by April 1, 2016, but the state should delay the rule-making process for at least six months to have a more thorough and accurate rule review begin the rule-making process at the end of 2016.

2. Administrative Rule Revisions. DRI found that the evaluation of the current administrative rules is inadequate and erroneous because the rules continue to allow services to be provided in institutional isolated settings, do not take into account a client-directed planning process and do not reflect the comprehensive transformation of Iowa's Medicaid system to managed care on April I, 2016. DRI recommends that the review be done by both an attorney and an expert on waiver services and that the rule-making process be delayed for at least six months.

RESPONSE:
Your comments are duly noted.

The rules review was conducted by IME subject matter experts with waiver and facility service management and oversight. The department believes that the review and conclusions derived from the analysis meets the intent of CMS. For all administrative rule changes, the draft rule is reviewed by the Iowa Attorney General's office prior to publication for public comments. Any resulting rule changes will go through a separate public comment period as part of the rulemaking process and comments on the specific changes, or suggestions for additional changes, can be made through that process.

In regard to HCBS services provided in a residential care facility, the commenter is making the assumption that these facilities are inherently institutional and not appropriate for HCBS. HCBS services may be provided in a facility based setting. The assessment process outlined in the STP determines whether a member is integrated or isolated from the community while living in the setting.

COMMENT:
Section 2.3.1.2 Policy Manuals

In its 9/4/15 letter (p. 2), CMS required DHS to provide a cross-walk of state policies and federal regulations. DHS appears to have taken a short-cut by stating that all policies will be updated once the Iowa Administrative Rules have been promulgated. However, DHS needs to list the applicable policies, identify which are currently not in compliance, indicate how the language in the policies will be revised, and when these revisions will occur.

RESPONSE:
The DHS manuals are based directly on the HCBS administrative rules and as such any results found in the review of the rules will also apply to manuals. As such, the manuals will be updated to reflect any rule change that occurs as identified in 2.3.1.1 of the STP. The rule making process allows for public comment and input into any proposed rule change.

COMMENT:

Section 2.3.1.3 Other Standards

The STP states that the provider agreements do not directly support or conflict with the settings regulations, but simply state that providers must comply with all applicable federal and state laws. This is too general and does not highlight the HCBS Settings Rule. Iowa will be transitioning from a fee-for-service Medicaid system to a managed care system on April 1, 2016. Both the agreements that DHS has with the three managed care organizations (MCOs) and the agreements between the MCOs and providers should explicitly require compliance with the Home and Community-Based Setting Requirements if the provider is providing HCBS services. ("HCBS Settings Rule"), 42 C.F.R. § 441.301(c)(4).

RESPONSE:
The Provider agreement (form 470-2965) is signed by all Medicaid providers (e.g., physicians, therapists, etc.) not just HCBS waiver providers and as such, inclusion of a reference to the settings regulation is not applicable to most Medicaid providers. The HCBS settings rules are being addressed through oversight specific to HCBS providers. The department's contracts with the MCOs explicitly require compliance with the settings regulation. CMS does not require states to address contracts in the systemic assessment and as such they were not included in this analysis.

COMMENT:
Section 2.3.2 Systemic Assessment: Settings Analysis (pp. 16-17}

The STP needs to include DHS' criteria for determining why settings where certain services are provided were determined to need further assessment, possible remediation or heightened scrutiny. The service settings in question are identified by(?) in the chart on pages 16 & 17 and are listed below:

Services by Program: Adult Day Care, Behavioral Programming, Consumer Directed Attendant Care (Agency or Assisted living Provider) Family and Community Support, Family Counseling & Training, Home-Based Habilitation, Mental Health Outreach, Prevocational Services, Respite, Supported Community Living and Residential-Based Supported Community Living (for children)

Will all settings where the above listed services are provided be subject to a site specific assessment?

RESPONSE:
The "rationale for determinations" on page 16 of the STP is clear in stating that the settings identified with a question mark (?) in the chart will undergo the assessment process which includes both the provider self-assessment and on-site assessments.

COMMENT:
Section 2.3.3 Preliminary Provider Self-Assessment Results

1. Self-Assessment Form. DHS should attach to the STP the instructions and form it used for provider self-assessments.

2. Methodology. The STP does not set forth the methodology it used to conduct provider self-assessments and needs to be more fully explained.

a. It appears that less than 500 assessments were completed. There is no indication that the assessments were completed by all providers.

b. Are the providers themselves concluding whether they are in compliance with the HCBS rules or are they simply providing information to DHS and DHS determines whether they are compliant based on the questions in the self-assessment.

3. Appendix A (Iowa HCBS Settings Based on 2014 Provider Self-Assessment

a. Does Appendix A represent all providers funded through 1915(1) or 191S(c) waivers? Does DHS keep a list of HCBS providers so that it can cross-check the provider's self- identification as an HCBS service.
b. Does Appendix A represent all HCBS providers in the State? If not, how is DHS going to create a complete list?
c. Appendix A list the provider/agency name, location, provider control, type of residence, number of members at the site, and service type. If the self-assessment is being used to determine whether the setting is in compliance with HCBS rules, "self- assessment" of compliance with the HCBS Settings Rules, Appendix A should also preliminarily indicate whether the setting falls into one of the categories below:

1. setting presumed fully compliant with home and community-based characteristics;
2. setting that may be compliant and with changes will comply with the regulation;
3. setting presumed to have institutional qualities but evidence may be submitted to CMS for heightened scrutiny review, or
4. setting that does not comply with the regulations.

DHS compliance determinations regarding specific providers and HCBS settings are not premature. Since the self-assessments were completed on June 30, 2015, DHS has almost a year to make its preliminary compliance determinations. If DHS is not ready to do this, it should indicate when this will occur. It's stated deadline of June 30, 2018 is too far in the future. This needs to be done earlier in the transition process, rather than later. It's Without this information, the individuals and entities performing the validation reviews, as well as the public, cannot validate whether the compliance determination is accurate.

RESPONSE:
Information, instruction and training on the HCBS Self-assessment process are available on line: http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment. As explained in the STP, the 2014 self-assessment results were the basis for the preliminary results which provided the state with a systemic baseline measure of compliance. The results for 2015 and future years will be validated through the other assessment processes outlined in the STP, and determinations regarding remediation will be based on the comprehensive information.

COMMENT:
3. Aggregate Data (Pie charts) (p. 18-21)

The structure of the charts regarding services and settings analysis are easy to follow. Although the charts list in the aggregate whether providers were generally compliant or non-compliant in responses to individual questions, the STP does not explain what "compliance" means. Instead of simply stating whether the provider response is "compliant," the STP should identify the number of settings that fall into the four categories specified by CMS in its September 4, 2015 letter:

a. Setting presumed to be compliant with the home-and-community based characteristics;
b. Settings that may be compliant and with changes will comply with the regulation;
c. Settings presumed to have institutional qualities but evidence may be submitted to CMS for heightened scrutiny review; and
d. Settings that do not comply with the regulation.

Non-Residential Services

The preliminary Provider Self-Assessment questions need to separate residential and non-residential services, such as habilitation and employment services to get a true picture of whether non-residential settings are complying with the HCBS settings rules. Appendix A lists the providers and settings where non-residential services are being provided. These providers should receive a separate self-assessment, using CMS' exploratory questions to Assist States in Assessment of Non-Residential Home and Community-Based Service Settings {https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services- and-supports/home-and-community-based-services/downloads/exploratory-questions-non- residential. pdf). The Self-Assessments should then be reviewed by independent contractors who are experienced in helping individuals who want to move from segregated facility-based employment and habilitation services to competitive Integrated employment and community- based habilitation services. We understand that DHS is currently collaborating with Iowa Vocational Rehabilitation Services and Iowan Workforce

Development to integrate their services. This collaboration needs to be described in the STP.

Corrective Action Plans (p. 20)

The STP states that any provider responses that stated "no" to the questions in the self- assessment, were instructed to submit a corrective action plan {CAP) to address the issue. The STP indicates that it was unable to collect data on the number of CAPs submitted because providers often combined issues related to the settings regulation with other issues requiring a CAP. DHS indicated that it is developing data tracking procedures to specifically identify CAPs related to HCBS settings issues, but fails to indicate when the data tracking procedures will be completed. DHS should be able to analyze the self-assessments that indicated non-compliance now. The "no" responses for the self-assessment questions range from 27 to 98 "no" responses out of a total of 500 responses. DHS should assign one of its employees or hire an independent contractor to analyze the responses and review and comment on the corrective action plans. This should be completed early in the 5-year transition process rather than DHS waiting until the end of the 5-year grace period to require corrections. In addition, DHS should provide in the STP its instructions for providers to complete corrective action plans, along with the requirement that the providers give DHS milestone dates for compliance actions.

RESPONSE:
Thanks for the comments. The 2016 self-assessment will be reviewed and modified to gather additional baseline settings information from providers**.**

COMMENT:
Section 2.3.3.2 Iowa Participant Experience Survey (IPES) (pp. 22-26}

The STP does not provide sufficient detail about the IPES results and refinements. Information responding to the following questions should be included in the STP:

1. In what specific settings were HCBS recipients surveyed? Residential, non-residential?

HCBS compliant, HCBS non-compliant. The survey provides no information about the types of settings in which members responded in the negative. Without this information, it is impossible for the state to determine which types of settings and which specific settings require remediation.

2. Are the 333 individuals surveyed just a sampling? Of how many total individuals?
3. IPES surveys were conducted between July 1,2014 and June 30, 2015. Were any surveys conducted since June 30,2015?

4. Who conducted the preliminary IPES survey? HCBS specialists? Case managers? others? What training do the IPES surveyors have to conduct the IPES? If case managers or providers are conducting the surveys, there may be a direct conflict of interest because their priority may be getting services for their clients even if the settings are non-compliant.
5. If members required assistance or reasonable accommodations with the IPES, who provided the assistance or accommodations?
6. How are the survey participants educated so that they know what choices and control that they have and what their rights are?
7. What percentage of the preliminary surveys were actually responded to by a family member on behalf of the participant? Was this family member the individual's guardian?
8. Will the IPES survey be conducted annually for each participant? Will the surveys be conducted after 2018?
9. Will "flags" that are inconsistent with the settings rule be immediately followed up on by the Quality Assurance Unit? (Case managers should not be assigned to do the follow- up because they have a conflict of interest). Is there a written process or time frame in which they are required to follow up with the participant/provider? Will there be documentation kept as to the resolution of the issue flagged in the IPES?
10. What oversight is being provided by IME or its contractors to determine that the IPES is reliable and valid?

In addition, there is no indication that there was a way to tie the participant experience survey to individual settings. Some of the questions in the survey are not useful for the HCBS requirements as they provide the individual no context, such as being a part of their planning process when the rule says the planning process should be driven by the individual. The results of the individual participant survey seem doubtful to the outside reader that they are an accurate reflection. For example, it seems doubtful that everyone who was restrained actively told someone on their team that they were restrained.

Finally, the IPES survey results are extremely vague. For example, one of the questions is "Do you feel you get to choose the things you want in your life?" Some of the missing questions that would promote person-centered and client-directed planning and compliance with the HCBS Setting Rule would be:

What things would you choose to do?
Where would you like to live?
With whom?
What jobs?
What education?
What training?
What Recreational activities?

What would you like to do to reach your goals??
Did you reach your goals?

RESPONSE:
The IPES tool has been in use by the HCBS Quality Oversight Unit for many years and is part of the approved waiver application with CMS for conducting quality oversight of HCBS services. The IPES is used to gather member specific information around the services they receive. The information gathered form the IPES is used in conjunction with other assessment tools and processes to get a baseline for services.

COMMENT:
Site-Specific Validation Process (p. 28)

Iowa originally planned to do assessments through an ongoing process associated with quality assurance/licensure, but CMS indicated the need for a point in time assessment to classify settings. Now the state has added assessments completed by the state's HCBS Quality Assurance Unit and community-based case managers working through the MCOs. It is not clear how these entities will be doing assessments or what the expected outcome is. Although the state has provided some information about training, there is no information in the plan about *how* these additional assessments will be done. For example, are the assessors talking to participants? If so, are they providing information on the rules to participants before asking questions about whether they think the setting is meeting the requirements? Are they talking to individuals outside the hearing of providers/staff in order to try to get unbiased information or are they recording their source of information? In addition, there is no information about protections from conflicts of interests as MCO case managers have an interest in not finding problems they would be asked to solve and the MCO has a conflict in not wanting to have to find new providers or offer more expensive, individualized services. There is also no information about any quality assurance mechanisms, including ensuring that the assessments and observations of community features are consistently done.

RESPONSE:
The department will use the provider self-assessment when assessing HCBS settings. For the assessments to be completed by case managers, the tool will be developed prior to use by case managers using the guidance from CMS in the exploratory questions and regular webinars they have provided.

COMMENT:
Approximately 500 HCBS providers conducted a self-assessment. DHS sent a survey to 96 randomly-chosen providers with only 57 returned. A response from 57 providers is not sufficient to provide qualitative information demonstrating practices in implementing the settings regulations. As a result, DHS surveyed only 10% of the 500 providers. DRI recommends the following additions to the STP:

- The survey should be attached to the STP.
- The STP needs to identify the methodology for identifying the 96 providers surveyed.
- what percentage of the percentage of the providers surveyed were residential providers? Non-residential providers?
- what percentage of the providers surveyed fell into each of the four compliance categories provided by CMS?
- What incentives were given to providers to return the surveys?
- What follow-up activities did CMS engage in to get a better return rate on the surveys.
- The results of the survey. How many providers indicated that they were implementing best practices to implement the HCBS Settings Rules. What were the best practices? Had any of the providers already come into compliance?

Provider Stakeholder Group. (p. 28) It is concerning that the state convened providers to discuss indicators of integrated settings and service delivery, along with examples of evidence that providers could gather to support the settings used in service delivery. While such an approach is helpful for providers, to not include HCBS participants and advocates in the creation of such guidance shows a fundamental misunderstanding of the perspective that is important in the HCBS regulations, that of the participant. Before being used, such a document or guidance should be provided for comment by participants and stakeholders. To do otherwise is essentially allowing those who may be violating the HCBS standards to set their own guidance.

- Even more concerning are the indicators the group came up with. The first indicator that "The majority of members receive most of their services in a setting that supports access to, and facilitates integration..." is contrary to the regulations and guidance that all of the individuals in a setting must be in a setting that meets the HCBS requirements.

RESPONSE:

Thanks for the comments. The provider stakeholder group was convened as a focus group to get feedback from a cross section of providers that will evaluated for HCBS settings. The focus group reviewed information and guidance from CMS as well as heightened scrutiny review findings from CMS reviews conducted in other states. The outcome of this focus group was a draft of setting indicators that may be used in provider evaluations of residential and non-residential settings.

COMMENT:

Preliminary Onsite Assessment by HCBS Quality Oversight Unit

a. The STP repeatedly refers to the HCBS Quality Unit, but insufficiently describes the Unit. How many staff on the HCBS Quality Oversight Unit? What are the qualifications of the reviewers?

b. What methods are used by the HCBS Specialists to validate the provider's responses? IF HCBS Specialists only look at self-assessments, can this data be relied upon? How do we determine that the self-assessments are complete and accurate?

c. The plan does not offer much information about how the HCBS qualities are being incorporated into the existing quality assurance process. Because the plan is heavily relying on this for both assessment validation and quality assurance, it should be more fully explained.

d. The STP states that there will be one year or three year intervals for existing providers and five year periodic reviews once during a five-year period. Five years is a long period of time between reviews. DHS indicates that approximately 40% of HCBS providers will have a site review in any given year. How many on site reviews will have been conducted by the 12/31/16 milestone that DHS has set.

e. How is the Quality Oversight Unit going to collaborate with the three managed care organizations? How is the Unit going to share information about non-compliance with the MCOs which need the information since they are required to comply with the HCBS settings rules in their agreements with the state?

f. Will DHS collect any data on which HCBS providers are non-compliant with the settings rules so that it can identify systemic issues?

g. Again on-site assessments would prove to be more reliable if done by any outside party. MCO Community-Based Case Managers are either employees or contractors of the MCO which presents a conflict of interest. Reliability would be greatly improved if assessment was done by an outside party which eliminates any conflicts of interest.

RESPONSE:

As noted earlier, the HCBS Quality Oversight Unit (QOU) is the independent, single entity that is responsible for quality oversight of all HCBS providers. This includes oversight and implementation of the setting rules. The HCBS QOU is responsible for coordinating quality assurance activities for the department.

COMMENT:

Section 2.3.5 Site-Specific Outcomes (Remediation)

1. Education and Training (p. 36, #1). The plan focuses on provider education and involvement and has very little, If anything, on participant and family education. There were initial education sessions in 2014, but no further plans. Education and training is especially needed for members and families in 2018 (before the 5-year grace period ends and non-compliant providers close their doors).

RESPONSE:
Duly noted. Additional training for all stakeholders will be provided as needed when the STP is approved and implemented.

COMMENT:
Sanctions (p37, #6). Unfortunately, the Iowa Administrative Code does not allow DHS to fine providers as a possible sanction for violations of the medical assistance rules. Iowa Admin. Code 441-79.2. The rules should be amended to allow DHS to levy fines to achieve compliance. This has been an effective tools used by the Iowa Department of Inspections and Appeals to get providers to comply. Iowa Admin. Code 481-56.3.

RESPONSE:
The Iowa Administrative Code 441-79.2(249A) identifies many ways the department may sanction providers for non-compliance. While the rules do not allow for fines to be levied against providers, they do allow a variety of sanctions up to and including termination from the Medicaid program. the department has found these sanctions to be effective in provider compliance with the rules of HCBS

COMMENT:
Non-Disability Specific Settings (p37, # 7). The language of the member transition paragraph only says a "choice of alternative settings" and does not reflect the requirement of having the choice of a non-disability specific setting. In general, the state seems to ignore the part of the rule that requires choice of non-disability specific setting as nothing in the plan indicates the state is examining the array of settings and the needs of the population to determine if it has an appropriate array of settings and can meet the non-disability choice requirement. In general, there does not seem to be an overall shift to more integrated settings. The state needs to continue to develop its capacity to serve individuals in settings that are integrated into the community and comply with the HCBS Settings Rules.

RESPONSE:
Thanks for the comments. The particular item referenced also states “the state will ensure that members are transitioned to settings meeting HCBS settings

requirements". The Department will continue work with providers to assure that all HCBS settings meet the community standards for integration.

COMMENT:
Alternate funding sources (p37, #7).

The STP does not say who will secure alternative funding. This should not be the role of an MCO case manager or coordinator.

The plan to secure alternate funding for participants that choose to remain in a noncompliant setting is disturbing because such funding often does not have the same type of stability that waiver service funding has. For example, if state or local funds are used to support the individual, the difference in funding and how the difference in services could affect a person should be fully explained to a participant before making the final decision to forego HCBS. The participant should also be fully aware of any difficulties in accessing HCBS, such as the current length and timeline of the waitlist. Any assistance in finding an alternative non-compliant setting flies in the face of the HCBS settings rules and maintains Iowa as an overly institutionalized state.

RESPONSE:
One of the roles of a waiver case manager, whether funded through an MCO or fee-for-service is to identify service needs and to funding sources to get service needs met. Services options are not limited to those provided solely through HCBS.

As noted earlier, the final outcome of the assessment and review process of an HCBS settings is to determine whether a specific setting meets the HCBS settings rule. During the review process, if a provider is found to be out of compliance with the rules, the HCBS Quality Oversight Unit will work with the provider to develop a plan to come into compliance. If a plan is either not accepted or a compliance review finds that a provider has not implemented the approved plan, the provider will be informed that HCBS funding is not available to waiver recipients receiving services in that location. This does not mean that services cannot be provided in that location, but rather that HCBS funding is not available to participants to fund services at the location.

If service locations are found to be out of compliance with the rules, the department believes that most members will secure new providers in locations that meet the setting standards or will find additional services to meet their needs. One of the foundations of person centered planning is member choice of providers and services received. A member may choose to receive services in non-compliant settings, but HCBS funding

will not be available for the services in non-integrated settings. As such, the department believes that STP does not need to be amended.

COMMENT:
Provider Closure Process (p 37-38, #7).

The STP states that "the state will use the existing provider closure process that uses a collaborative approach involving IME, community-based case managers, providers and advocates to assist members in finding same and acceptable alternate housing and arrangements. However, the existing closure process involves facilities licensed by the Iowa Department of Inspections and Appeals (DIA) and includes representatives from DIA, IME, the long-Term Care Ombudsman (LTCO), and Disability Rights Iowa. Since HCBS settings are not licensed by DIA, HCBS settings would not be within the jurisdiction of the existing closure team and process. The LTCO would not be involved because it also represents individuals in licensed settings, such as nursing facilities. The STP needs to explicitly state who would be on the HCBS settings closure team and what the protocol for the team would be.

RESPONSE:
The IME has separate processes for facilities closure and HCBS provider closure. While the processes are similar, the entities involved in the process are included based on the type of facility that service provider that is closing. The IME works with the provider and case managers to assure that needed services are identified and transition to appropriate services are made

CHANGES TO THE STP:

The following changes have been made to the STP and will be included in STP submitted to CMS on 4/1/16. A word strikethrough (e.g., ~~strikethrough)~~ identifies language that is removed and an <u>underlined</u> word is added language:

1. Lockable units (page 2 of the STP):

When a residential setting is owned or controlled by a service provider, additional requirements must be met:

- At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.
- Each individual has privacy in their sleeping or living unit. This includes having entrance doors <u>to the member's living and sleeping unit</u> which can be locked by the individual with only appropriate staff having keys; individuals having a choice

of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.

- Individuals have the freedom and support to control their own schedules and activities, including having access to food at any time, and having visitors of their choosing at any time.

2. STP updates, information, and announcements.

The following info was added to page 31 of the STP.

14	Ongoing information, updates and announcements	Ongoing updates and information about the implementation of the Iowa statewide transition plan will be available on the department website at: http://dhs.iowa.gov/ime/about/initiatives/HCBS .	4/1/16	3/17/19

3. Stakeholder input.

The following info was added to page 31 & 32 of the STP.

15	Ongoing stakeholder input from members, families, advocates, providers and other interested parties.	The department shall seek stakeholder input and feedback on the implementation of the statewide. At a minimum, the department shall provide opportunity for stakeholder input every six months though statewide webinars, focus groups or other means of input	4/1/16	12/31/18

As follow up to the HCBS Settings survey (ID # 3 above) sent to providers, a focus group of providers and HCBS Quality Assurance staff was gathered for three meetings and one conference call (ID #4). This intent of the is focus group was to gather input from HCBS providers and HCBS Quality Oversight staff and develop a set of indicators that identify what services would look like in HCBS settings. The outcome of this focus group was the creation of four indicators for use by providers and quality oversight staff for development, provision and oversight of HCBS services to assist providers to meet HCBS Settings requirements. Examples of evidence to support the implementation of the indicators were also developed. These draft indicators will receive additional stakeholder input from member's and advocates prior to use.

4. Technical Errors

The following changes are made to reflect errors in the STP:

p. 30. Community-based case managers from Iowa's ~~four~~ three MCOs will perform onsite reviews of residential HCBS providers. Providers will be randomly selected based on a statistically valid sample of members taken at the 95% confidence level.

p.3-4. Brain Injury Waiver (CMS Waiver # IA.0299) – offers services for those who have been diagnosed with a brain injury due to an accident or illness and who meet the nursing facility, skilled nursing facility, or ICF/ID level of care. Members must be at least one month of age ~~but less than 65 years of age for this waiver~~.

5. Provider owned and controlled settings.

The language for provider owned and controlled settings listed on page 19 of the STP was used in the 2014 self-assessment in which providers responded and baseline data was gathered. As such, the language will not be changed in the STP. However, the definition of provider owned and controlled settings will be updated on the 2016 self-assessment to reflect the CMS guidance (below) and will be used in the assessment and review process moving forward:

> "If the individual leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled. If the HCBS provider leases from a third party or owns the property, this would be considered provider owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, we would presume that the setting was provider controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants".

6. Summary of comments received.

Per CMS, the STP to be submitted on April 1, 2016, will only include a summary of the comments received, and not the full list of comments received and the department's response in full. In the name of transparency and goodwill, the department will post all comments received and responses to those comments that have been developed by the department. The DHS website: http://dhs.iowa.gov/ime/about/initiatives/HCBS will be updated under "News and Announcements"

*Notes on methodology: Comments of a similar nature have been grouped together with a single response provided for each group. Written comments are included verbatim, with the exception that general comments (such as thanking the department for the opportunity to comment, or asking for copies of the presentation) have been removed.