Public Comments and Responses for the Iowa HCBS Waiver Amendments and Renewals (Including HCBS Settings Transition Plans) March-April 2015

Process:
Public comment was taken from March 4, 2015 through April 3, 2015 for the Children's Mental Health Waiver and the AIDS/HIV Waiver. Public comment was taken from March 16, 2015 through April 15, 2015 for the Intellectual Disability Waiver, the Brain Injury Waiver, the Elderly Waiver, the Health and Disability Waiver, and the Physical Disability Waiver and for the statewide settings transition plan.

The full waiver amendment or renewal documents were posted on the IME website along with the settings transition plan for each waiver and the statewide settings transition plan. All of the documents were also available for viewing in DHS offices across the state for persons who may not have internet access. The public was invited to submit comments through a dedicated email address or by delivering or mailing written comments directly to the Iowa Medicaid Enterprise. Comments were received from nine individuals.

Persons submitting comments:
Shelly Chandler; Iowa Association of Community Providers
Ron Christensen; Hope Haven Area Development Center
Melissa Cloud; HCBS Caregiver and Advocate
Jayna Grauerholz; Disability Rights Iowa
Mary L. Jankowski, MA, LMHC, LMSW; HCBS Caregiver and Advocate
Ari Ne'eman; Autistic Self Advocacy Network
William Nutty; Leading Age Iowa
Susan Osby; Polk County Health Services
Deborah VanderGaast; Tipton Adaptive Daycare

Comments and Responses:
COMMENT:
I would like to comment on the Iowa Medicaid Service Settings Transition Plan. As the state transitions it's Medicaid rules to comply with CFR 441.301(c)(4) and 42 CFR 441.710(a), I would like to see day care centers included in the list of appropriate service settings. On January 1, 2014, daycare centers and registered daycare home were eliminated as a category of Medicaid provider because there were conflicts in the child care and Medicaid regulations. This occurred despite the fact that Iowa law says that Interim Medical Monitoring and Treatment (IMMT) services are "monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting." Clearly child care providers were intended to be included as Medicaid providers. Unfortunately, a number of child care providers stopped providing Medicaid services because of the rule change. As a result, children with disabilities are forced to receive care in their homes where they have limited

opportunities to interact with their peers. They usually sit in front of the television instead of having the same activities and opportunities that other children have at daycare.

My Medicaid compliance consultant and my child care licensing consultants are confused by my blended services and policies because of the unresolved conflicts between regulations. I became a certified community provider in July, but I had to separate my Medicaid and daycare policies despite the fact that my Medicaid services are provided at my daycare center in a fully integrated environment.

The new federal rule lists certain kinds of settings that, usually, will automatically be considered "institutional" and not home and community-based, including places that are designed to provide many different kinds of services just to people with disabilities. I asked about my services at a recent Medicaid provider training, and my daycare complies because my setting is completely integrated and does not separate the disabled kids from their peers. I see my business model as becoming a standard for community-based services for children with special needs, but the current program rules are not supporting it. I think this transition time is a great opportunity to build a foundation that supports integrated special needs child care. Since the new Federal rules make daycares an ideal location for community-based services, there needs to be an effort to resolve conflicts between child care and Medicaid program regulations to allow more children to receive services in an inclusive environment with their non-disabled peers. (VanderGaast)

RESPONSE:
The January 1, 2014 change in rules referred to in the comment pertained to qualifications to enroll to provide certain HCBS services, and is unrelated to the HCBS settings regulation or Iowa's transition plan. The federal regulation and Iowa's transition plan do not exclude child care centers in the community as settings in which HCBS may be provided; however, Medicaid does not pay for child care.

COMMENT:
We are writing regarding service delivery settings in Iowa that we believe are not in compliance with the recently-issued regulations on Home and Community-Based Services. We have identified your state as one that includes examples of one type of impermissible setting—gated communities and farmsteads, such as the Homestead's farm program in Pleasant Hill—that we would like to bring to your attention.

We urge the State to conduct a more exhaustive review of its provider network, both to identify other examples of gated communities and farmsteads, a category of service-provision we believe to be impermissible under the new settings regulation, and to identify other residential, employment and day services that are not permissible under the new settings regulation.

The final rule requires settings to be integrated in and support access to the broader community, provide opportunities to seek competitive integrated employment, support engagement in community life, and support control over personal resources. The final rule also requires that people with disabilities choose their own service settings and have choices that are not disability-specific. Additionally, CMS issued guidance that describes characteristics of settings that tend to isolate. One of those characteristics is

a location where people with disabilities receive “residential, behavioral health, day services, social and recreational activities, and long term services and supports” all on the same site without having to leave.1

The settings listed above are examples of a model that claims to be an alternative to large institutions or group homes but that in reality isn’t community-based. These settings tend to isolate people with disabilities and prevent meaningful access to the broader community. People living in these settings are housed primarily with other people with disabilities. Although some settings invite people without disabilities to live in the same housing arrangements as service recipients with disabilities, these individuals are often staff members or volunteers. As a result, residents with disabilities often only interact with people in the surrounding community on specific dates or while working in provider-owned enterprises, such as a farm stand, or “community service” days in which members of the public are invited into the setting. This limits opportunities for full integration and sends a message that the residents with disabilities are projects, not peers. Because of their congregate character and failure to tailor their services or supervision of residents to individual need, these settings often have an overall service cost that is far higher than available waiver funding; as a result, the settings frequently require additional payments from Medicaid recipients or their families in the form of "tuition" or required "donations."

Disability-specific “farms” or “ranches” are one example of a setting that isolates people with disabilities. Residents with disabilities live and receive services entirely on the farm or ranch, which is usually owned by service providers. People with disabilities receive both housing and day services at the same site. Day services may include organized activities such as growing crops, raising animals, and other outdoors activities or crafts. Farm work may be unpaid or paid at rates below minimum wage. Disability-specific farms or ranches typically market these day activities as therapeutic or rehabilitative. Staff usually live on the farm or ranch. These settings are distinguishable from ordinary farms where people with disabilities may choose to live or work.

Villages and gated communities, like ranches, house many people with disabilities in a small cluster of homes in an area offset from the surrounding community. The entire village or gated community is often referred to as a “campus.” Staff usually live in the same buildings as residents with disabilities. A limited number of non-disabled people who are not staff may also live on the premises. Nevertheless, the properties are marketed as a special location only or mostly for people with disabilities and offer limited opportunities to interact with the community outside the confines of the campus. Residents with disabilities may have jobs inside the village or gated community, such as in a convenience store or in a sheltered workshop.

In addition to the geographic isolation of these communities, many settings also impose non-individualized restrictions on residents’ daily choices and activities, such as 24/7 surveillance cameras or motion sensors for all residents. Such violations of resident privacy by a provider-owned residential setting are in violation of the new home and community-based settings rule.

These settings must be contrasted with individual decisions to live with roommates or housemates who might also happen to have disabilities or to live on a farm, a ranch, or near the homes of other friends or acquaintances who have

disabilities. These campuses are provider-owned and typically do not offer individuals the opportunity to decide who provides their services, set their own schedule, or access regular transportation to community settings outside of the farm, ranch, or campus.

As you move forward with the five-year transition planning process, we strongly encourage you to include strategies to transition people currently in these settings to other settings that are in compliance with the regulations. (Ne'eman)

RESPONSE:

The Centers for Medicare & Medicaid Services (CMS) has allowed a transition period of up to five years for states to come into compliance with the regulations. States are required to submit transition plans that outline the process for assessment and remediation of HCBS settings within the state. Iowa has submitted transition plans for all seven of our HCBS Waiver programs as well as a statewide transition plan. These plans have not yet been approved by CMS; however, Iowa has begun implementation of the transition plan activities.

The approach outlined in Iowa's transition plans capitalizes on our existing quality assurance processes which utilize an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline. Our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis, as we currently do for other state and federal requirements.

In regard to the specific settings (gated communities and farmsteads) mentioned in your letter, Iowa has not made an across-the-board determination that these settings are noncompliant. However, as part of our transition materials, we have released a guidance document on settings with the potential effect of isolating individuals receiving HCBS from the broader community, which does include settings similar to farmsteads and gated communities, and which identifies that these settings may indicate increased risk of isolating people from the broader community.

As you are likely aware, the federal regulations do not define acceptable HCBS settings based on specific locations, geography, or physical characteristics, but rather focus on the nature and quality of the member's experiences. Any of these settings in Iowa will be individually assessed for compliance, and if noncompliance is determined, remediation will be required. Depending on the degree and nature of noncompliance, remediation could range from corrective action by the provider, to relocation of individuals to compliant settings.

COMMENT:

I am a caregiver and an advocate of an individual with a disability served under Iowa's HSCB Waiver Program. I was recently notified that the State of Iowa has proposed a transition plan for a setting analysis for several waivers. This plan has not yet been finalized and public comment is welcomed.

Upon reviewing the various proposed transition plan(s) it appears the focus on these proposed plans are compliance and quality assurance. Although these two topics are both very important, I feel that this plan is missing a very critical element, the representation of the consumer. In order to proceed with the proposed transition successfully it is essential that all of the parties are involved in these discussions, keeping in mind and including the end user, or the individual receiving services under the HCBS waiver. I think we all would agree that having access to valuable consumer feedback and input and involving the consumers and/or the advocates is a necessity not an option. By engaging consumers and/or their advocates more issues can be identified and feedback can be shared on potential negative impacts to the consumer and/or gaps identified can be remediated or prevented. This pro-active rather than reactive approach would beneficial to all and most importantly make things more transparent.

Like most business project managers understand, it is essential that all parties impacted must be involved, engaged and represented in a project in order for that project to be successful. I propose that before proceeding with the draft plan that the project team re-evaluate their approach, include consumers and/or their advocates in this discussion and that changes are made to include language which will represent consumers. Consumer's voices must be heard, considered, and proportionately represented in discussions and proposals going forward. Consumer representatives would include parents, caregivers, advocate, and individuals providing and coordinating care or the selection of service providers. (Cloud, Jankowski)

RESPONSE:

In developing Iowa's transition plan we have included several methods of seeking stakeholder involvement, including that of individuals receiving HCBS services and their family members and advocates. For the statewide plan and the Intellectual Disability (ID) Waiver plan, a comment period was held in May 2014 which included six stakeholder forums at various locations around the state. Another public comment period was held in November 2014 which included the statewide transition plan as well as the plans for the Brain Injury (BI) Waiver, the Elderly Waiver, the Children's Mental Health (CMH) Waiver, the Health and Disability (HD) Waiver, the Physical Disability (PD) Waiver, and the AIDS/HIV Waiver. Stakeholder forums were also held by webinar at that time. The public comment periods held in March and April of 2015 included all seven of Iowa's HCBS Waivers as well as the statewide transition plan. In all of these instances input was sought from consumer advocacy organizations such as the Olmstead Consumer Task Force, Disability Rights Iowa, the Iowa Brain Injury Association, the Iowa Developmental Disabilities Council, NAMI Iowa, and ASK Resource Center. Consumers and advocates have given input and had their questions answered through this process. The state transition plans are meant to be living documents that will change and evolve as the process continues over the next four years, and consumer and advocate input will continue to be sought throughout that time.

COMMENT:

1. How will this transition fit with the MCO's and regions?
2. Would like to include within the document that regions are involved in the sharing of data and involved in planning and development of community based settings.
3. Within the Iowa HCBS Setting Analysis, there should not be a distinction between provider owned and controlled housing, this was eliminated from the rules. (Osby)

RESPONSE:
1. The statewide transition plan and the waiver specific transition plans do not at this time include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.
2. The MHDS Regions are listed as a stakeholder in the public comment section of the transition plans. While it is accurate that the regions are involved in the sharing of data and in planning and development of community based settings, the state does not believe that it is necessary to list those as separate activities within the plan, as these are part of the existing and ongoing role of the regions.
3. The federal settings regulation does still include the distinction for provider owned and controlled settings, and sets out additional requirements for such settings. As such, Iowa will retain that distinction within the settings analysis.

COMMENT:
Public comment rules require an opportunity to comment on the substance of state plans. The transition plan must include the substance of how the HCBS programs will change. The current condition of the transition plans lacks substantive information necessary to adequately give the public and other stakeholders the opportunity to make reflective comment. DRI encourages Iowa Medicaid Enterprises (IME), a division of the Iowa Department of Health Services (DHS) to thoughtfully examine how each of the comments and questions below might help Medicaid recipients, their families and guardians, providers and others better understand how Iowa intends on transitioning its service delivery system to comply with the new HCBS Settings rules. DRI urges IME to revise the transition plans to include information responding to these questions so that stakeholders can truly understand the transition plan and its components in the most transparent and accessible manner possible.

The state plan for waiver settings transition and the individual waiver settings transition plans are identical and contain the same action items, descriptions, proposed start dates and proposed end dates, and cite the same sources or documents. Therefore, the list of comments and questions contained in this comment are referring not to one individual transition plan explicitly but rather the whole plan for Iowa's transition to comply with the HCBS Settings rules. Also, it appears that the waiver amendments are primarily intended to incorporate transition plans. Therefore, comments on the transition plans also apply to the amendments. (Grauerholz)

RESPONSE:

In regard to the comments asserting that Iowa's transition plan lacks substantive information to give stakeholders an opportunity to make reflective comment, we believe the transition plan and related materials set out the state's approach in adequate detail, and that there has been adequate opportunity for public input. In addition to the actual transition plans, the state has published a variety of other related materials including a white paper, the results of our settings analysis, responses to comments from previous comment periods, and guidance documents on settings that have the potential to isolate and providing exploratory questions for providers. Additionally, the state has held numerous stakeholder forums across the state and by webinar which were attended by over 300 individuals. Nevertheless, we will provide responses to all of your following questions and comments within this document.

COMMENT:
The following is a list of general comments and questions pertaining to the transition plans and the language contained within:

1. The added explanatory narrative at the top of each of the three sections is helpful as it provides a summary description of the content of the section. (Grauerholz)

RESPONSE:
The department appreciates the comment.

COMMENT:
2. The "players" column was removed from the original transition plans issued by IME. The most recent version of the transition plans do not indicate which agencies are responsible to complete the actions. IME should consider including this column to future transition plans because inclusion of the agency or agencies responsible for the specific action items would provide greater transparency and accountability for the completion of the task. (Grauerholz)

RESPONSE:
The "players" column was removed because the responsibility for the activities listed in the transition plan lies primarily with the IME. When necessary, stakeholders have been noted in the description column for each item or in the explanatory narrative at the top of each section.

COMMENT:
3. The transition plans need to be explicit in whether IME or a managed care organization (MCO) will be responsible for specific action plans, as this is not delineated in the current RFP either. (Grauerholz)

RESPONSE:
The waiver amendment and renewals and the transition plans under consideration during this comment period do not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate

waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.

COMMENT:
4. Anything in the action plan and description portions of the transition plan which include behavioral health organization (BHO) language may not be relevant after the MCO transition. Please make any necessary revisions for relevancy of transition plans. (Grauerholz)

RESPONSE:
The waiver amendment and renewals and the transition plans under consideration during this comment period do not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.

COMMENT:
5. Timelines that are “ongoing” are not sufficient. There should be proposed specific milestones in the transition plans to indicate when the first phase of an activity will be completed and when subsequent phases will be done. This will not only provide some predictability as to when activities shall be completed but will also indicate Iowa’s progress in complying with the HCBS rules. (Grauerholz)

RESPONSE:
The transition plan notes certain activities as “ongoing”. This is because the approach outlined in the transition plans capitalizes on our existing quality assurance processes which utilize an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline. Our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis, as we currently do for other state and federal requirements.

COMMENT:
6. This particular comment is specifically regarding the ID waiver, Appendix C, C-5. The State makes assumptions about the status of sites and feels that a large proportion of HCBS members are served in settings that fully comport with HCBS setting requirements. DRI has concerns that the State is making assumptions that the settings will comport will the settings rule without first going through the process to determine actual compliance with the new settings rule. Assumptions of compliance should be

purported only after the appropriate evidence is gathered to support claims of compliance. (Grauerholz)

RESPONSE:
We believe that many HCBS settings will comport with the rule because Iowa has for many years promoted the concepts of integration and choice for members receiving HCBS; however, as the Iowa settings analysis describes, the only settings that are assumed to fully comport with the regulation are those where the member owns the housing or leases housing which is not provider owned or controlled, and supported employment provided in an integrated community setting. All other settings will be required to go through the assessment processes to determine actual compliance.

COMMENT:
7. The amended waivers should address how Iowa intends to eliminate the waiver waiting lists or alternatively significantly increase the number of slots on each waiver. The amended waivers should reference that this language will also be included in any contract(s) made between the State and MCOs. Not receiving waiver supports puts individuals at risk of institutionalization when the individual may only need certain services and supports to remain in or return to the community. The waiver slots should be increased to illustrate Iowa's dedication towards community integration and the recognition of the necessity for Olmstead compliance. The increase in slots should be memorialized in any contract between the State and an MCO. The contract should also include provisions for gradual increases at explicitly stated intervals. This addition of explicit direction in MCO contracts regarding the increase of waiver slots and the necessary gradual increase of slots at timed intervals will protect vulnerable populations from losing services and being put at risk of institutionalization should DHS or an MCO decide to later "pare down" a waiver program. MCOs should understand Iowa's dedication towards community integration and be tasked with specific guidance and regulations to follow in order to carry out those steps towards integration. (Grauerholz)

RESPONSE:
The number of annual funding slots is based on a budget projection for each waiver. There are many factors that go into these projections such as the overall funding level for waiver services, and funds appropriated by the legislature for wait list reduction. Other factors such as projected growth in enrollment, and the attrition from the waivers is also considered.

The waiver amendment and renewals and the transition plans under consideration during this comment period do not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.

COMMENT:
Section 1: Assessment: Settings Analysis

1. What is the intent of the settings analysis - is this an education piece for providers?
2. Will the subsequent self-assessment be developed from this?
3. Will this be a template for future assessment tools? (Grauerholz)

RESPONSE:
1. The settings analysis is intended to be a starting point for the assessment process. It is meant to be a high-level overview of where typical settings are expected to fall on the continuum of compliance. As stated in the settings analysis document, it does not imply that any specific provider or location is noncompliant solely by classification in the analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan
2. No, the provider self-assessment has been developed based on the requirements of the federal regulations, and is already in use for the 2014 assessment cycle. The self-assessment form is also available on the IME website at: http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment.
3. It is not expected to become a template for future assessment tools.

COMMENT:
Section 1: Assessment: Provider Enrollment Processes
1. The language in the Description column needs to be updated to reflect changes which may occur with the change to Managed Care. There may not be BHOs under managed care.
2. Explanation needs to be provided as to which specific agency, agencies, or actors will be responsible for provider enrollment.
3. The proposed end date for this action item was 12/31/2014. Have the Provider Enrollment Processes been completed?
4. Can the Provider Enrollment Processes be made available to the public on the DHS website? (Grauerholz)

RESPONSE:
1. The waiver amendments and renewals and the transition plans under consideration during this comment period do not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.
2. Provider enrollment and certification is done by the IME.
3. The waiver provider application has been updated to include verbiage noting when a provider self-assessment must be submitted. The self-assessment must be completed prior to certification to provide HCBS services. The certification process includes assessment of the settings in which HCBS will be provided, and if needed, remediation as outlined in the transition plans.
4. The basic application process for enrollment of waiver providers is on the IME website at: http://dhs.iowa.gov/ime/Providers/enrollment/WaiverEnrollment. Please note

that in addition to the application process, providers must be certified to provide HCBS as indicated in part 3 of this response.

COMMENT:
Section 1: Assessment: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses
1. Which agency, agencies, or actors are developing this system?
2. If a contractor is developing the system, what is the contract price for developing the system?
3. What is left to be completed on the GIS system?
4. Will the GIS system be able to separate HCBS sites by types of services? (Grauerholz)

RESPONSE:
1. – 3. The IME will be doing an analysis using GIS software that is already licensed to the IME. There is no system development required.
4. Not at this time. The IME will explore that possibility as additional data is collected in the future.

COMMENT:
Section 1: Assessment: Onsite Assessment
1. The Onsite Assessment needs to develop a baseline for each individual site and setting. This can be achieved by conducting an initial baseline assessment of all providers and then setting milestones. An Ongoing Proposed End Date is insufficient. Milestones will ensure that providers and members are both prepared for the transition and have adequate time to successfully make the transition.
2. The Onsite Assessments need to be prioritized so that providers presumed to not yet be in compliance are assessed first. The self-assessment may be a starting point to begin prioritization.
3. What will be the frequency of Onsite Assessments?
4. What oversight is being provided to determine that the Self-Assessments are reliable and valid? (Grauerholz)

RESPONSE:
1. The approach Iowa has proposed in our transition plans capitalizes on our existing quality assurance processes which utilize an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline. All HCBS providers who are required to submit a self-assessment will have completed the first step in the assessment process during the first year. The “ongoing” end date has been used in the plan because our quality assurance processes will continue even after the transition deadline to assure

that providers who were in compliance will continue to meet the requirements on an ongoing basis, as we currently do for other state and federal requirements.
2. Onsite assessments will be done during the regular cycle of recertification reviews, periodic reviews, focused reviews, and targeted reviews. If concerns are identified through another component of the assessment process such as the self-assessment, additional or expedited onsite assessments may be done. Additionally, providers may request technical assistance from their HCBS Specialist at any time.
3. Onsite assessments will occur during the regular quality assurance review cycle. Certification reviews are done at enrollment for new providers and at one-year or three-year intervals for existing providers. For periodic reviews, every provider will have an onsite review once during a five-year period. For focused reviews, a random selection of providers is taken such that all providers will be reviewed during a five-year cycle. Targeted reviews are done as the result of a complaint made to the IME about a provider, so any time an HCBS Specialist is onsite for a complaint investigation, there could also be findings related to the settings regulation. Additionally, any time a plan of correction is required, the IME may choose to do a follow-up onsite review. With this review cycle, approximately 40% of HCBS providers will have an onsite review in any given year.
4. Since the self-assessment is not a standardized instrument there are no statistical measures of reliability and validity being done. It appears the comment is focused on verification of responses. For each provider, the given responses on the self-assessment will be verified during the onsite review done by the HCBS Specialist. Self-assessment results may also be reviewed by the manager of the HCBS Quality Assurance unit and by IME policy staff as needed.

COMMENT:
Section 1: Assessment: Enrolled HCBS providers self-assessment
1. The Proposed Start Date is 10/1/2014. Are any of the Self- Assessments already returned? If so, please provide the results.
2. What oversight is being provided to determine that the Self-Assessments are reliable and valid?
3. If providers do not comply with the Self-Assessment, which agency, agencies, or actors will be responsible for demanding compliance or issuing sanctions?
4. If a provider does not comply with the Self-Assessment, what sanctions will be imposed? (Grauerholz)

RESPONSE:
1. As noted in the transition plan, the annual self-assessment is released to providers annually on October 1 and is due to IME annually on December 1. As such the responses for 2014 have been returned. Aggregate results are being compiled.
2. Please see the response to part 4 of the previous comment.
3. The IME is responsible for any actions that result if a provider does not submit a required self-assessment.
4. If a provider does not submit the self-assessment, the IME HCBS Quality Assurance unit will make a follow-up contact to attempt to obtain the self-assessment. If the

provider still does not comply, a referral is made to the IME Provider Integrity unit. The Provider Integrity unit may sanction the provider as allowed under Iowa Administrative Code 441—79.2.

COMMENT:
Section 1: Assessment: Other projects collecting HCBS setting data
1. There is a possible conflict of interest in having a provider membership association accessing the State's progress in complying with the HCBS Settings rules because of possible bias by the association towards finding member settings in compliance.
2. Is there a contract with Iowa Association of Community Providers (IACP) to perform these services?
3. If so, how much is the amount of the contract?
4. What settings data is to be collected by IACP?
5. How will the State determine whether the IACP data is valid and reliable? (Grauerholz)

RESPONSE:
1. The provider association is not assessing the state's compliance, nor is it assessing compliance of any enrolled providers. In an early draft of the transition plan this item was included because the state wanted to access a survey of residential providers that had reportedly already been conducted. Upon further communication, it was learned that no such survey existed, so this item was revised so that general information could be gleaned about the issues that providers will face in coming into compliance with the regulations.
2. – 5. There is no contract and no data will be collected; this is just an open dialog on provider issues.

COMMENT:
Section 1: Assessment: Iowa Participant Experience Survey (IPES)
1. Please provide a copy of the IPES on the IME website.
2. Who will be conducting the IPES?
3. What training will conductors of the IPES have received in order to administer the IPES in a valid and reliable manner?
4. If members require assistance with the IPES, who will provide member assistance?
5. What reasonable accommodations will be provided to members requiring assistance taking the survey?
6. What formats does the survey come in?
7. What oversight is being provided by IME or its contractors to determine that the IPES is reliable and valid? (Grauerholz)

RESPONSE:
1. The IPES files (MS Word documents) are available on the DHS website at: http://dhs.iowa.gov/sites/default/files/IPES%20Tools.zip.

2. The IPES is conducted by HCBS Specialists from the HCBS Quality Assurance unit at the IME.
3. The HCBS Specialists who conduct the survey all have education and experience in applicable fields such as social work, case management, or nursing with mental health experience. They receive training in health literacy, cultural sensitivity, and motivational interviewing which includes instruction to ask questions as they are formatted and to record responses without personal bias.
4 – 5. Contact is made with the member's case manager prior to completion of the survey, and with the member at the time of scheduling, both of which provide opportunities to alert the HCBS Specialist of any assistance or accommodations that may be needed. The IPES interview is conducted at the place and time of the member's choosing. If the member is unable to participate, a family member can be designated to respond on behalf of the member, however member participation is strongly encouraged. Typical accommodations made in the past have included use of interpreters or TDD, but we strive to provide any necessary assistance or accommodations.
6. The survey is an interview that is conducted in person or over the phone depending on the member's preference.
7. The IPES is a customized version of the Participant Experience Survey (PES) tools developed by CMS for use with HCBS programs. More information on the PES tools is available at: http://hcbs.org/hcbs/article/participant-experience-survey-pes-tools. Certain questions on the IPES are flagged so that follow-up by the case manager is initiated for issues that are identified.

COMMENT:
Section 1: Assessment: Onsite Assessment Results Report
1. If the Results Report is limited to the Onsite Assessment only, IME should also issue reports on the action items listed in this section. All reports should be posted on the IME website. (Grauerholz)

RESPONSE:
1. Due to the nature of Iowa's proposed process being a continuous cycle of assessment and remediation, point in time reporting may not be feasible with all of the activities in this section. Nevertheless, the IME will make all reasonable efforts to report results and publish them on the IME website.

COMMENT:
Section 2: Remediation Strategies: Informational Letters
1. Who will the informational letters be sent to?
2. How are the informational letters being transmitted to members? By case managers delivering them to members personally? By delivery through regular mail? By posting on the IME website? Other?
3. If the recipients of the letters are providers or DHS case managers, are they tasked with relaying the content included in the informational letters to members?

4. Who will be assisting members in understanding the content of the informational letters if a member has questions about the informational letters?
5. How many members access alternative formats of the informational letters? Braille? Large print? Audio? (Grauerholz)

RESPONSE:
1. Providers are the intended audience for Informational Letters.
2. All Informational Letters are posted on the IME website at: http://dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins. Additionally, anybody can subscribe to receive Informational Letters by email on the Iowa Medicaid Portal Access (IMPA) system at: https://secureapp.dhs.state.ia.us/impa/unAuthSubscribe.aspx.
3. – 4. Providers are the intended audience for Informational Letters. Providers and case managers are certainly free to share the content with members as they believe is necessary. In such a case, the provider or case manager should assist members in understanding the content if needed.
5. The IME supplies Informational Letters electronically, and as such they may be enlarged, or converted to audio or Braille by screen reader software.

COMMENT:
Section 2: Remediation Strategies: Iowa Administrative Code
1. What agency is drafting the proposed regulations?
2. If there is more than one agency responsible for enforcing the HCBS Settings rules, the Rules need to be explicit regarding the remediation process and sanctions to ensure uniformity and consistency.
3. What are the range of sanctions that will be included in the rules for non-compliance?
4. What is the timeline for the Notice of Proposed Rule Making for each of the proposed new rules? (Grauerholz)

RESPONSE:
1. The IME is drafting administrative rules.
2. DHS will be the only agency responsible for enforcing the HCBS settings rules.
3. Possible sanctions for providers are already set forth in rules at 441—IAC—79.2.
4. The IME hopes to begin the formal rulemaking process by July 2015, although this is an estimate because some factors such as review by the Attorney General's office can affect the timeline. The normal rulemaking process typically takes a minimum of six months. The department does not have authority for emergency rulemaking related to these rules.

COMMENT:
Section 2: Remediation Strategies: Provider Manual Revisions
1. Who is responsible for revising the provider manual?
2. When will the revisions to the provider manual be completed? (Grauerholz)

RESPONSE:

1. The IME is responsible for all revisions to Provider Manuals.
2. The Medicaid Provider Manuals are reviewed on a rotating quarterly basis, so all manuals are reviewed and updated once per year. The timeline for completion as stated in the transition plan is 12/31/2015.

COMMENT:
Section 2: Remediation Strategies: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment
1. Education and HCBS Compliance Understanding should be provided to all enrollees and not limited to new enrollees.
2. What does the Education and HCBS Compliance Understanding plan consist of? When will it be completed?
3. What agency or agencies will be providing the Education and HCBS Compliance Understanding? (Grauerholz)

RESPONSE:
1. This item is specifically related to enrollment of new providers. Education and technical assistance on any HCBS topic including the settings requirements is available to existing providers through their HCBS Specialist.
2. The transition plan does not propose the development of a plan for this activity, it proposes that enrolling providers will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements. These efforts are currently in progress.
3. The IME is responsible for this activity.

COMMENT:
Section 2: Remediation Strategies: Provider Assessment Findings
1. What action(s) or omission(s) trigger a requirement for a corrective action plan? This should be specifically indicated in the transition plan, the rules, and the provider manual. (Grauerholz)

RESPONSE:
1. Any finding of noncompliance based on an assessment activity will trigger a corrective action plan (CAP).

COMMENT:
Section 2: Remediation Strategies: Provider Individual Remediation
1. Instead of the State allowing “reasonable time frames” for large infrastructure changes, the State should impose specific timeframes and deadlines and the onus should be on the provider to then request an extension to come into compliance.
2. What is the process for submitting requests for heightened scrutiny review to CMS?
3. Which agency, agencies, or actors will be responsible for issuing a corrective action plan (CAP)? (Grauerholz)

RESPONSE:
1. As consistent with our current quality assurance processes, timeframes that will be set out in a CAP will be specific for that provider and location. The “reasonable timeframes” language in the transition plan should be read within the context of the entire description of that item. The prior sentence states “State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.” In other words, the specific timeframes allowed will be set with consideration of the nature of the noncompliance and the steps that will be necessary to achieve compliance.
2. The process for heightened scrutiny review is determined by CMS. They have provided some information on the topic as part of their Settings Requirements Compliance Toolkit available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.
3. The IME is responsible for this activity.

COMMENT:
Section 2: Remediation Strategies: Data Collection
1. Which agency, agencies, or actors will be responsible for collecting data and reporting to DHS and/or IME?
2. What data will be collected? (Grauerholz)

RESPONSE:
1. This item is not about data collection from external entities; it refers to IME collection of data based on the assessment and remediation activities outlined in the transition plan.
2. Data will include information on assessment findings, CAPs issued, and remediation status.

COMMENT:
Section 2: Remediation Strategies: Onsite Compliance Reviews
1. This action plan should be completed within six months of the transition plan.
2. Which agency, agencies, or actors will be responsible for completing the onsite reviews?
3. What are the HCBS Certification Review Tools? Please post them to the DHS or IME website. (Grauerholz)

RESPONSE:
1. This activity refers to onsite reviews to check compliance for providers that have submitted corrective action plans (CAPs) in response to a finding of non-compliance; as such these reviews will be completed in a timeframe relative to the acceptance of the provider’s CAP, not relative to the transition plan.
2. The IME is responsible for this activity.

3. The HCBS Certification Review Tools refers to the materials used by HCBS Specialists when conducting provider certification reviews. The IME prefers not to post these materials to our website as we would like providers to focus their compliance efforts (not just for HCBS settings, but for all HCBS requirements) on meeting the published rules and regulations rather than focusing on the content of the tools.

COMMENT: Section 2: Remediation Strategies: Provider Sanctions and Disenrollments
1. Please list all of the sanctions which can be imposed.
2. Which agency, agencies, or actors will be responsible for disenrollment?
3. Which agency, agencies, or actors will be responsible for providing notice to the service recipients that his/her provider has been disenrolled due to non-compliance with the HCBS Settings rule?
4. How will notice be provided to service recipients? (Grauerholz)

RESPONSE:
1. Sanctions for providers are published in administrative rules at 441—IAC—79.2.
2. The IME is responsible for this activity.
3. As with any HCBS provider disenrollment, the IME will contact the case managers for any members that may be affected by a provider disenrollment. The case managers will provider notice to the members as well as assist them in finding other providers with compliant settings that can meet their needs.
4. As with any other change in service, the member will receive a notice in writing.

COMMENT:
Section 2: Remediation Strategies: Member Transitions to Compliant Settings
1. The protection and advocacy agency (P&A) should be notified, in writing, 60 days before any closure takes place in order to best provide advocacy to affected members. (Grauerholz)

RESPONSE:
1. Although the IME would not be able to share individual member information, we will make every effort to provide a general notice to the P&A agency in the event of a closure.

COMMENT:
Our primary concern throughout the federal HCBS settings rulemaking process was and continues to be senior housing and services providers' continued ability to care for Iowa's seniors under the Elderly Waiver in light of the stringent HCBS settings rule characteristics.

We believe Iowa's implementation of the HCBS settings rule should take into account that HCBS are provided in very different settings, including assisted and independent living, HUD affordable housing, and market rate senior communities (including continuing care retirement communities). These are the places Iowa's seniors

call home. To prevent low-income seniors from receiving services in these settings simply because they may be adjacent to a public institution (per the settings rule) is counterproductive.

As Iowa transitions towards Medicaid manage care as part of the Governor's Iowa High Quality Healthcare Initiative, it's imperative that application of the HCBS settings rule encourage development of HCBS infrastructure. Recognizing the current lack of affordable senior housing in Iowa, LAI encourages the Department to apply the HCBS settings rule in a manner that doesn't exacerbate this shortage.

A significant part of the initiative's savings will be generated by a program to divert people from facility placement and into HCBS. Unfortunately, this service infrastructure is lacking in many parts of Iowa, especially rural areas.

Iowa's proposed draft transition plan (Main Module, Attachment 2) does not reflect the intent of the final CMS rule. The final rule includes a "heightened scrutiny" standard for determining HCBS settings. Iowa's plan includes the "rebuttable presumption" that residential care facilities, provider-owned housing, assisted living on a nursing facility campus and any location adjacent to an institutional setting is "presumptively non-HCBS" (Main Module, Section 3, Iowa HCBS Settings Analysis). This places the full burden on the provider to prove HCBS settings compliance; these are the very facilities that will be depended upon to provide housing and care for Elderly Waiver recipients through the Iowa High Quality Healthcare Initiative's facility diversion program.

This language is also in conflict with CMS's own guidelines regarding Continuing Care Retirement Communities, where provider-owned RCFs, independent and assisted living units are on the same grounds or adjacent to that of a nursing facility. From the CMS website: "Guidance on settings that have the effect of isolating individuals receiving HCBS from the Broader Community." The document states:

"In CMS' experience, most Continuing Care Retirement Communities (CCRCs), which are designed to allow aging couples with different levels of need to remain together or close by, do not raise the same concerns around isolation as the examples above, particularly since CCRCs typically include residents who live independently in addition to those who receive HCBS." (Page 3, paragraph 1).

LAI asks that Iowa's HCBS transition plan reflect the federal language and to also identify CCRCs as integrated communities by their nature, and not subject to HCBS settings compliance scrutiny. (Nutty)

RESPONSE:

In regard to the comment that the transition plan settings analysis includes the rebuttable presumption that residential care facilities, provider-owned housing, assisted living on a nursing facility campus and any location adjacent to an institutional setting is presumptively non-HCBS, this is incorrect. Those settings are all included in the category of "settings that may be compliant, or with changes will comply with HCBS characteristics". The only settings that Iowa has included in the category of "presumed non-HCBS" are those that are set out in the federal regulation, which includes settings located in a building that also provides inpatient institutional treatment, settings on the grounds of or adjacent to a public institution, or settings that isolate participants from the broader community.

In regard to Continuing Care Retirement Communities (CCRCs), CMS acknowledges that most CCRCs do not raise the same concern regarding isolation; however the department can only be assured that such locations meet the HCBS settings criteria through assessment of those settings and the members' experiences in those settings, and as such we will not deem these settings as being incompliance. In any HCBS provided in with a setting that congregates a large number of people with disabilities in one location there is increased risk that the location may have some of the qualities of an institution. We expect that the settings across the state will fall on a continuum from those that need little or no remediation to others that may need extensive remediation. All such locations where HCBS is provided will be assessed for compliance with the regulations. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community.

COMMENT:
Increase in the Elderly Waiver enrollment cap**.** LAI welcomes any new waiver "slots" allowing addition numbers of seniors to receive services in the place they call home. While 300 new slots (from 9,200 to 9,500, Appendix B-3 Number of Individuals Served) are welcomed and much-needed, they represent a little more than 3% increase in current numbers. Again, the Iowa High Quality Healthcare Initiative plans include diverting seniors from nursing home placement to Elderly Waiver slots that will fill quickly and likely result in a waiting list. (Nutty)

RESPONSE:
The Department appreciates the comment, however the Medicaid budget does not allow for additional increases in the Elderly waiver funding slots at this time. The legislature would need to specifically appropriate funds to add additional funding slots to the Elderly Waiver. Additionally, please note the waiver amendment under consideration during this comment period does not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.

COMMENT:
Elderly Waiver Assisted Living Services. The Department is to be commended for developing the structure for this program. Reimbursement for room and board under the Elderly Waiver in assisted living is prohibited. The AL Services program allows for reimbursement for additional tenant supervision services. This reimbursement helps somewhat lessen providers' financial losses when providing Elderly Waiver in assisted living. (Nutty)

RESPONSE:
Although the referenced changes were approved in a previous waiver amendment, the department appreciates the comment in support of these changes. It is our hope that all recipients of HCBS throughout Iowa will benefit from the opportunity to live and thrive in truly integrated community settings.

COMMENT:
The new paradigm in senior care. As Iowa moves forward with the Iowa High Quality Healthcare Initiative to increase quality and control costs for Medicaid-eligible Iowans, it's imperative that seniors and the disabled have more choices, rather than fewer, regarding housing and services. This is especially true in rural areas, where providers often must collaborate in order to offer HCBS. In order to maximize the amount of HCBS services in a rural state like Iowa, the state needs to provide the maximum amount of flexibility allowed under federal law to allow for creative partnerships between HCBS and institutional providers and the efficient use of resources. (Nutty)

RESPONSE:
The department appreciates the comment. It is our hope that all recipients of HCBS throughout Iowa will benefit from the opportunity to live and thrive in truly integrated community settings of their choosing.

COMMENT:
Under the Intellectual Disabilities waiver, providers currently cannot be reimbursed when an individual living in a waiver site is hospitalized or is off site for a 24 hour period to visit family, go on vacation or any other reason. It is our feeling at Hope Haven that providers should be able to receive funding for these days just as we are able to do so when and individual is living in an intermediate care facility. Providers still incur the same costs in regards to direct and indirect services. For example, because one individual in a 3 person site is gone, does not eliminate the need for staff to be present for the other two remaining individuals. Our costs remain. Therefore, we would respectfully request that the rules be changed to allow providers to charge for these days. (Christensen)

RESPONSE:
The ID waiver pays providers for the provision of direct service provided to a member. The rate setting process for daily Supported Community Living (SCL) services is based on the provider's projection of the number of days the member will receive services each year. A provider submits a D-4 schedule to the Iowa Medicaid Enterprise (IME) Provider Cost Audit (PCA) Unit initially and when significant changes occur for a member that affects the rate of reimbursement for a provider. Over the past several years there has been much discussion with stakeholder groups to make changes to the rate setting process for the ID and BI waivers with no consensus. The department will continue to engage with providers and other stakeholders in this discussion.

COMMENT:
Main Module: The document indicates that the state sent this renewal application in on February 18, 2015. What is the process and timeline for incorporating any changes based on public comment/feedback? (Chandler)

RESPONSE:
The renewal application was submitted on February 18, 2015, but was subsequently un-submitted on March 16, 2015 so that public comments could be taken on the application. After the 30-day public comment period, a summary of the public comments received and the state's responses is submitted to CMS as part of the renewal application process. The summary addresses any comments that were not adopted and the reasons why, and any modifications to the waiver that were made as a result of the public input process.

COMMENT:
Appendix B: B-2 Individual Cost Limits – IACP has advocated for the elimination of individual cost limits in the HCBS ID waiver, especially with the expected transition of the entire Medicaid program to managed care. DHS has indicated it uses an aggregate cap for its contract with CMS, yet the Department achieves budget neutrality of its aggregate by imposing individual caps.

The Scope of Work associated with the managed care RFP indicates in section 4.4.5.2 (Service Needs) that individual monthly caps will continue to be applied and that managed care contractors are expected to identify and utilize non-waiver services for individuals reaching their monthly cap. Section B-2 of the state's HCBS ID waiver renewal application is incomplete regarding the indication of the state's intent to impose individual cost limits.

IACP supports the elimination of the individual cost limits. It appears however, that the state intends to continue using monthly individual cost caps, as indicated in its managed care RFP. If this is accurate, then sections B-2-a, B-2-b, and B-2-c of the waiver renewal application should be completed.

B-2-a asks the state if there is an individual cost limit when determining whether to deny home and community based services or deny entrance to the waiver to an otherwise eligible individual then select from a menu of options for determining the cost limit.

B-2-b addresses the method of implementation of individual cost limits to determine in advance that the individual's health and welfare can be assured within the cost limit.

B-2-c addresses participant safeguards when there is a change in condition of an individual that, post entrance to the waiver, requires the provision of services in excess of the cost limit to assure the health and welfare of the individual. The state has not made a selection of the following available options:

1. The participant is referred to another waiver that can accommodate the individuals' needs.

2. Additional services in excess of the individual cost limit may be authorized

Nor does the state indicate, as required in this section, to specify the procedures for authorizing additional services, including the amount that can be authorized or any safeguards that are in place. (Chandler)

RESPONSE:
The ID Waiver renewal application under consideration during this comment period is for the time period beginning July 1, 2014, and does not include any changes related to Iowa High Quality Health Care Initiative (aka Medicaid Modernization). Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future. There will be another public comment period related to those amendments at that time.

COMMENT:
Appendix B: B-3 Number of Individuals Served – B-3-a, B-3-b, B-3-c

The state indicated in a previous section that it intends to transition 25 individuals per year from facility settings to waiver settings. However, in B-3-a and B-3-c the maximum number of unduplicated participant and the maximum number of participants served at any point during the year both remain the same throughout the course of the five year renewal at 14,203 and 12,912 respectfully. Shouldn't the state increase each of these limits to accommodate its stated planned transitions for each year? (Chandler)

RESPONSE:
The number of annual funding slots and the number of unduplicated participants are based on a budget projection for the ID waiver. There are many factors that go into these projections such as the Medicaid funding allocation for ID waiver services, wait list reduction funds appropriated by the legislature, projected growth in enrollment, and the attrition of slots (due to members moving out of state, not meeting ID waiver criteria at the continued stay review, voluntary discharge, and death).

The biggest driver of the number of slots and unduplicated count is the fiscal appropriations for the ID waiver. In previous years, the ID waiver had a projected slot and funding increase of three percent annually. With the projected Medicaid shortfalls this year and in future fiscal years, the projected growth (both fiscal and slots) was removed.

The slot attrition rate used for the ID waiver is 500 slots per year based on historical trends. Based on this rate, there is no need to increase either the number of point in time slots or the unduplicated slot count for the fiscal year for the purpose of adjusting for the increased reserved capacity slots.

COMMENT:
Appendix B: B-3-c addresses reserved waiver capacity. The state currently reserves 72 waiver slots for use by children in Residential Based Supporting Community Living and an additional 100 slots (proposed to increase to 125) for individuals living in an ICF/ID facility who may choose to access services in the ID waiver instead. It is IACP's position

that both reserves are excessive in relation to the actual number of individuals that access reserved slots. As the state has implemented a waiting list (section B-3-f) for HCBS ID waiver slots, it is actually preventing access to the waiver for otherwise eligible individuals while holding slots in reserve that do not get used. (Chandler)

RESPONSE:
The number of reserved capacity slots requested is based on budget allocation and potential use to transition individuals to HCBS ID Waiver services. The reserved slots for individuals transitioning from an ICF/ID were increased by 25 slots per year due to the growth of the Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) initiatives. With the closing of several ICF/ID facilities this year, it is anticipated that most if not all of the reserved capacity slots will be accessed as the MFP members transition to the ID waiver after MFP funding ends.

Likewise, the RBSCL program has seen recent growth in the number of youth accessing RBSCL. This includes members that are living in out-of-state placements and using MFP funds for transition. The state believes that the current number of reserved capacity slots is appropriate based on the projected growth of the MFP program and BIP initiatives.

COMMENT:
Appendix J – Cost Neutrality Demonstration: The formula used to demonstrate cost-neutrality of the waiver is dependent on some data sources that are referenced by the department but not enumerated. IACP requests disclosure of the following:

- Complete calculation with all data elements of Factor D – estimated annual average per capita Medicaid cost for HCBS services in the waiver program
- Complete calculation with all data elements of Factor D' – estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
- Complete calculation with all data elements of Factor G – estimated annual average per capita Medicaid cost ICF/ID care that would be incurred for individuals served in the
waiver, were the waiver not granted. Also, please specify if the Medicaid costs of the two state run institutions are included in this calculation.
- Complete calculation with all data elements for Factor G' – the estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted. (Chandler)

RESPONSE:
Factor D is the average per member costs for providing HCBS ID waiver services and D' (prime) is the average per member Medicaid cost for all applicable Medicaid services. Factor G is the average per member costs for providing ICF/ID services and G' is all other Medicaid costs. The ID waiver cost neutrality formula requires the total HCBS ID Waiver costs plus all ID Waiver member Medicaid costs must be less than or

equal to the total ICF/ID costs plus all other ICF/ID member Medicaid costs. This is expressed as: D + D' < G + G'. Supporting data are as follows:

Factor D	Unduplicated Recipients	Total Costs	Est. Factor D	Est. Factor D' (Prime)
Renewal Year 3 (Base)	10,234	264,164,786	25,812	12,163
Renewal Year 4	10,741	285,867,940	26,615	12,772
Renewal Year 5	11,063	303,396,760	27,424	13,410
Waiver Year 1	11,395	338,487,006	29,705	14,081
Waiver Year 2	11,737	374,686,686	31,924	14,785
Waiver Year 3	12,089	412,292,257	34,105	15,524
Waiver Year 4	12,452	450,735,863	36,199	16,300
Waiver Year 5	12,825	492,778,430	38,422	17,115

Factor D' and G'

Service	*Expenditures*	*# of people*	*Cost per person*	*Factor*	
				D'	G'
Physician	114,146,919	234,451	487	X	X
Dental	35,704,671	121,413	294	X	X
Other Practitioner Svcs.	12,323,896	96,126	128	X	X
Outpatient	113,660,067	158,803	716	X	X
Clinic	76,168,627	143,262	532	X	
Home Health	69,508,460	21,976	3163	X	
Lab X-Ray	17,657,619	159,820	110	X	X
Prescribed Drugs	366,931,835	273,391	1342	X	X
Capitated Payment Svcs.	178,456,154	322,054	554	X	X
Other Care Svcs.	312,360,500	82,570	3783	X	X
Personal Support Svcs.	26,364,290	25,007	1054	X	X
				12,163	8,469

Factor G

Service	*Expenditures*	*# of people*	*Cost per person*
ICF/SNF Services	232,108,187	2,326	99,789

	Undup Recipients	Total Costs	Est. Factor D	Est. Factor D (Prime)	Est. Factor G	Est. Factor G (Prime)	Combined D and D'	Combined G and G'
Renewal Yr 3 (Base)	10,234	$264,164,786	$25,812	$12,163	$99,789	$8,469	$37,976	$108,257
Renewal Yr 4	10,741	$285,867,940	$26,615	$12,772	$105,776	$8,892	$39,386	$114,668
Renewal Yr 5	12,175	$333,883,716	$27,424	$13,410	$112,122	$9,337	$ 40,834	$121,459
Waiver Yr 1	12,540	$371,851,168	$29,653	$14,081	$118,850	$9,804	$43,734	$128,654
Waiver Yr 2	12,916	$411,199,591	$31,836	$14,785	$125,981	$10,294	$46,620	$136,275
Waiver Yr 3	13,304	$452,251,067	$33,994	$15,524	$133,540	$10,809	$49,518	$144,348
Waiver Yr 4	13,703	$494,465,786	$36,085	$16,300	$141,552	$11,349	$52,385	$152,901

Waiver Yr 5	14,114	$540,635,365	$38,305	$17,115	$150,045	$11,917	$55,420	$161,962