



Iowa HCBS Settings Transition Plan Public Comments May 2014

Public comment was taken from May 1, 2014 through May 31, 2014. The public was invited to submit comments through an email address (HCBSsettings@dhs.state.ia.us) and stakeholder forums were held at six locations across the state (Fort Dodge, Iowa City, Davenport, Council Bluffs, Des Moines, and Sioux City). Additionally, presentations on Iowa's transition plan were done for the Olmstead Consumer Task Force and a group consisting of representatives of several disability advocacy organizations.

Notes on methodology: Comments are grouped by topic, and within each section comments of a similar nature may be grouped together with a single response provided for each group. Comments from a single person that covered multiple issues may have been divided into topics as noted above; however, written comments are included verbatim, with the exception that general comments (such as thanking the department for the opportunity to comment) have been removed. Comments received in-person have been paraphrased based on notes taken by department staff present at the stakeholder forums.

Persons submitting comments:

Duane Alons, Iowa Legislature (forum)
Marilyn Althoff, Hills and Dales (forum)
Kathie Anderson-Noel, Muscatine County Case Management (forum)
Anne Armknecht, Vera French Community Mental Health Center (forum)
Cindy Baddeloo, Iowa Center for Assisted Living (email and forum)
Bob Bartles, Hope Haven (email)
Mary Baumhover, Family member of HCBS consumer (forum)
Maggie Beavers, Linn County MHDS (forum)
Denise Beenk, Vera French Pine Knoll (email)
Alan Blakestad, Ameriserve (forum)
Paula Blessman, Family member of HCBS consumer (forum)
Larry Boeve, Hope Haven (forum)
Craig Bradke, Abbe, Inc. (forum)
Diane Brecht, Abbe, Inc. (forum)
Debra Bustad, Family member of HCBS consumer (email)
Rich Byers, MIW, Inc. (forum)
David Comstock, Childserve (forum)
Shelly Chandler, Iowa Association of Community Providers (email and forum)
Jeanine Chartier, Char Mac Assisted Living (forum)
Jennifer Crosbie, Caregiver Homes (email)
Kim Dank, Muscatine County Case Management (forum)
Linda Dunshee, Link Associates (forum)
Tresa Feldman, Howard Center (forum)
Marsha Glenn, HCBS Quality Oversight Unit (forum)
Phil Grove, Village Northwest (forum)
Bob Hebl, Discovery Living Inc. (email)
Kari Hildring, Goodwill of the Great Plains (forum)
Steve Hodapp, VODEC (forum)
Theresa Hogensen, Assisted Living Partners (forum)
Jodie Jansen, Family member of HCBS consumer (forum)
Deanna Johnson, Crossroads of Western Iowa (forum)

Cheryll A. Jones, Prevention of Disabilities Policy Council (email)
Cindy Kaestner, Abbe, Inc. (email)
Stacy Kiser-Willey, Vera French Community Mental Health Center (forum)
Shawn Lahr, Emeritus Senior Living (email and forum)
Pat Laursen, Howard Center (forum)
Geoffrey M. Lauer, Olmstead Consumer Task Force (email)
Sharon Lukes, Western Home Community (forum)
Mark Lawrence, Family member of HCBS consumer (forum)
Rhonda Mart, New Hope Village (forum)
Betty Marxen, Pursuit of Independence (forum)
Rebecca Mattas, Emeritus at Northpark Place (email)
Diane McElmeel, Jones County Case Management (email)
Cathy Miller, Genesis Development (forum)
Paul Murrell, Family member of HCBS consumer (email)
Sherri Nielsen, Easter Seals Iowa (email)
William Nutty, Leading Age Iowa (email and forum)
Melissa Patten, Faith Hope and Charity (forum)
Delaine Petersen, ARC of East Central Iowa (forum)
Sandra Pingel, Genesis Development (forum)
Shari Porter, The Pride Group (forum)
Joan Portz, Northwest Living/Opportunity Living (forum)
Mark Ramthun, Family member of HCBS consumer (forum)
Kris Richey, Adams-Taylor-Union County Case Management (forum)
Mariann Roemen, Good Samaritan Society (forum)
Hallie Salmen, Sunrise Retirement Community (forum)
Clint Sargent, Crossroads of Western Iowa (forum)
Maureen Seamonds, Family member of HCBS consumer (forum)
Sarah Seifert, Vera French Community Mental Health Center, (forum)
Lisa Schwanke, Hope Haven (email)
Marilyn Shaffer, Family member of HCBS consumer (forum)
Shelly Sindt, Elderbridge Area Agency on Aging (forum)
Dan Strellner, Abbe, Inc. (email)
Mark Stromer, VODEC (email and forum)
Sherry Stowe, MFP Transition Specialist (forum)
Nathan Vander Plaats, Goodwill of the Great Plains (email)
Karen Walters Crammond, Polk County Health Services (email)
Cindy Weimold, Faith Hope and Charity of Storm Lake (forum)
Casey Westoff, Systems Unlimited (forum)
Denise Wiederin, Friendship Haven (forum)
Jeff Wilson, Crest Services (forum)
Barry Whitsell, Village Northwest Unlimited (email)
Lu Wingfield, Mainstream Living (email)

I. Individual Initiative, Autonomy, and Independence in Making Life Choices – Comments and questions in this section center on requirements in the federal regulations that seek to ensure that individuals receiving Medicaid HCBS have full opportunities to make choices and exercise optimal control over all aspects of their daily living. As such, many comments do not specifically address the Iowa transition plan per se, but rather are seeking clarification or interpretation of the federal regulation.

COMMENT: The draft rule also states, “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”. I agree with the notion that HCBS services should not be delivered in a controlled or institutional setting in which rigid controls are utilized for the convenience of staff. My sincere hope is that service delivery has evolved past the time when services were delivered in accordance with facility rules and protocol. It is; however, important to remember that thousands of Iowans receive HCBS support in congregate living environments. Many people served have specific team approved restrictions based on their assessed need. For example, an individual who has diabetes and unlimited access to food items may well be in serious danger. A member who desires to have a family member with a record of violent felonies spend time in a home shared with others may well be placing themselves and others at risk. As care providers we are constantly challenged with balancing promoting choice and independence at all times, while also safeguarding the safety and well-being of all parties who reside in congregate settings. (Hebl)

COMMENT: How about if they have a guardian that says they want certain food locked up? (McElmeel)

RESPONSE: The regulations allow for modifications when necessary, based on an assessed need of the individual. If a modification is needed, it must be documented that less intrusive methods have been attempted, that the restriction is being done through the person-centered planning process with the individual’s informed consent, and time limits must be set to review the restriction and measure its effectiveness.

COMMENT: The CMS rules are predicated on client choice. When an individual chooses to live in a non-integrated setting, what is the burden of proof that this is a result of individual choice? (Kaestner)

COMMENT: The HCBS regulations state that individuals should have “free choice” of where they live and work...but yet these regulations are restricting rights and choices. (Whitsell)

COMMENT: According to the letter, the rule requires that the setting “Is selected by the individual from options that include non-disability specific settings”. Will revisions to regulations account for member choice even if that choice is to remain in the setting in which they currently reside? Or, if a particular setting is deemed non-compliant by DHS, will the member have to move even if they don’t want to? (Stromer)

RESPONSE: Since their inception, Medicaid HCBS programs in Iowa have been designed to serve individuals in integrated settings. The federal regulation seeks to ensure that services and supports delivered through HCBS programs are truly integrated. The regulations assure that individuals will have choice in where they live, from whom they receive services. If an individual chooses to live in a setting that is not integrated and as such does not qualify as an HCBS setting, then funding through a source other than Medicaid HCBS will need to be arranged, or the individual may have to move to an integrated setting that does qualify for HCBS.

COMMENT: Contrary to many theories and beliefs that individuals with disabilities enjoy “being out in the public,” many of the individuals we serve would much rather be in a setting that feels safe and comfortable to them. The settings provided by the agency allow individuals to interact

with individuals with similar challenges and offers an environment that feels safe and inviting. (Whitsell)

RESPONSE: The regulation ensures that individuals receiving HCBS are given opportunities for, and provided with access to the larger community. The regulation does not require individuals to participate in activities in the community to an extent greater than the individual chooses.

COMMENT: My siblings are going to ask me what did you find out and what can I tell them? (Lawrence)

RESPONSE: The federal regulation aims to improve the quality of life for many individuals receiving HCBS. The intent is to expand opportunities to receive supports in the most integrated setting, and ensure that individuals have access to community living to the same extent as individuals not receiving HCBS. Further, the intent is to ensure that individual rights are not unduly restricted.

COMMENT: Members need choice in all settings. Does that mean if they don't have choice at work, are they excluded from Waiver? (Richey)

RESPONSE: If the individual is receiving HCBS services and supports in the work setting, they will need to have choices to the same extent as others working in the same setting who are not receiving HCBS.

COMMENT: I've heard that everyone has to have the ability to have a job in the community to be considered integrated. But what 85-year-old wants that? (Baddeloo)

RESPONSE: The federal regulation says that full access to the greater community includes "opportunities to seek employment and work in competitive integrated settings". That does not mean that all persons receiving HCBS must work in the community, but that an individual should have the opportunity to do so if that is what the person chooses.

COMMENT: We are a child services provider of Residential Based Supported Community Living (RB-SCL) provided to age 16-21. How different is this for kids? For kids we have restrictions from parents & guardians. (Patten)

COMMENT: How will these issues be looked at for children, will it be any different? What about us who serve them as a child and they become an adult? For example, right now often it's the provider signing the lease. Also some of the rules are weird for 16-17-year-olds and that needs to be considered. What kind of allowance can be made for providers like us? Some of these rules don't work well for people who are not adults. (Comstock)

RESPONSE: In terms of individuals having the ability to make their own choices, the comparison would be to other children the same age who are not receiving HCBS. In both cases there would still be a parent or legal representative making age-appropriate choices in the best interest of the child.

COMMENT: Regarding the item about the member choosing their roommate—that can get tricky. Will you offer us additional guidance? Sometimes the member is part of the process and sometimes they are not at all, they're just introduced to their new roommate. (Miller)

RESPONSE: The regulations require that in provider owned or controlled settings, the individuals who are sharing units must have a choice of roommates. Simply assigning an individual to share a unit and introducing the person to the roommate does not meet the intent

of the regulation. The department has modified the CMS guidance offering exploratory questions to produce an Iowa-specific document called “Exploratory Questions for Assessment of Home and Community-Based Services (HCBS) Residential Settings”. This document is available on the department website at: <http://dhs.iowa.gov/ime/about/initiatives/HCBS>.

COMMENT: Individual sleeping quarters—does it have to be a single room? What about two sisters who want to room together, or a married couple? (Chartier)

RESPONSE: In the responses to comments that were published with the final rule, CMS clarified that the option for a private room does not mean that all providers must offer private rooms, only that the state must assure that private rooms are available within the HCBS programs in the state. Individuals receiving HCBS can share a room with another recipient of HCBS as long as both individuals are given the choice of roommates.

COMMENT: A lot of this is going to be sorted out by the participant experience survey. The conversation is driven by CMS and what they think is the big picture. Are they losing sight of what the individual is comfortable with, enjoying being productive, etc? Don't downplay what the participant survey shows. Different people will choose different environments. (Alons)

RESPONSE: We agree that the experience of the individual receiving HCBS is very important, and the inclusion of results from the Iowa Participant Experience Survey (IPES) will be an essential part of the assessment process. We do recognize that different people will make different choices, and the federal regulation attempts to optimize those choices. People receiving HCBS services must be provided with opportunities for access to the community, and given access to the greater community when that is the choice they make.

II. Provider Owned or Controlled Settings – Comments in this section center on the federal regulations that set out specific requirements for settings that are owned or controlled by the provider of HCBS services. As such, many comments do not specifically address the Iowa transition plan per se, but rather are seeking clarification or interpretation of the federal regulation.

COMMENT: How do you define “controlled by a provider”? (Portz)

RESPONSE: In the responses to comments that were received by CMS in regard to the federal rule, CMS clarified that a setting is considered provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS. Iowa will use the same standard.

COMMENT: There are a number of requirements in the draft transition plan that are specifically applied in instances where service providers own or control the residential environment in which individuals are served. Many service providers and entities own such properties and it is a widely held perception that people served, their families and other stakeholders prefer such an arrangement. Provider ownership of such properties allows for prompt repair and maintenance of properties, facilitates member specific home modifications and adaptations - and may prevent conflicts that tend to arise when one member's family owns a home where other members also reside. Our non-profit organization provides services in a number of member and family owned homes, but in many instances it is not practical or even possible to do so. When you consider the shortage of accessible housing options that prevails throughout Iowa, many service organizations would not even be able to secure appropriate housing to meet member needs if the service provider is not allowed to own homes. Given these factors, discouraging provider

property ownership seems contrary to the delivery of quality services, and to the notion of offering a true choice in service delivery options to people served. (Hebl)

COMMENT: Another issue is the provider owning or controlling the housing. The home where Luke lives cost about one million dollars to build. Luke's only source of income is SSI. That money has to cover the costs of housing and other basic needs. That is not a large pool of money pay for rent etc. When the home Luke lives in was built, the provider of Luke's care (and the owner of the home) was able to raise funds from the community to help defray a large part of the cost to build the home. For example, the land was donated. Much of the labor was donated or was provided at a greatly reduced rate. Many of the other costs such as building materials, heating and cooling equipment etc. was either donated or provided at a significantly reduced cost. This effectively reduced the actual cost to the provider for building this facility. Therefore the rent cost to Luke is greatly reduced to what it would have been had the provider had to pay full market value to get the home built. One of the reasons that the provider was able to get the donations to build this home at such a low net cost (such that Luke can actually afford to pay his rent out of his limited income) was that the donors knew that the provider was going to use these donations to provide a home for Luke and the others served there. Certainly Luke and the others served there do not have the financial resources to own their own home. If the home was owned by a third party it seems extremely unlikely that a third party would have been able to get the donations to build the home, since a third party would not be a provider. Thus it seems almost a certainty that Luke would not be able to afford the rent to live in such a home. In short, it is precisely because the provider owns the home and the community knows what the home will be used for, that the money was able to be raised to build the home and make the rent affordable for Luke. (Murrell)

COMMENT: The concept of not allowing providers to own buildings in which HCBS services are provided is very unreasonable. First of all, these types of buildings require improvements and equipment that ordinary buildings do not have. Providers are willing and able to make these improvements to their buildings because it is in the best interest of their consumers. Also, thanks in large part to contributions that are received from donors of the agency, they are able to afford to make such improvements and modifications. If these buildings were to be owned by investors, they are not going to be willing to make modifications on a regular basis to their buildings because they would not see a return on their investment. (Whitsell)

COMMENT: If provider owned or controlled housing is eliminated, who should own the buildings that house our disabled family members? If the families could afford to buy a home and contract individual services for their family members, wouldn't they already be doing so? I know our family would have gladly done so if it were an economic possibility. In my opinion, the provider does not control my daughter's housing – the residents who live there and their families have meetings and make group decisions about the running of the home. The housing was built totally by donated labor and materials, including the land; but it is my belief that ownership of the home was transferred to the provider when the construction was completed and the girls were allowed to move in. Does this exclude my daughter's home from eligibility? (Bustad)

COMMENT: What happens to individuals who cannot rent or lease directly from a landlord due to a criminal history background? Or the individual who may have Medicaid coverage but no income, so cannot secure housing. Where will these individuals be able to live and receive services? Our concern is this could lead to increased homelessness. Most of the integrated housing options in our community require the renter to have 2.5 times the rent cost as monthly income. Many of the individuals needing these supportive services do not meet that income requirement. How will they be able to secure independent housing? How will HUD housing be impacted by these rules as this is one of the few affordable options for individuals with disabilities and some of the HUD housing is high density housing units? (Kaestner)

RESPONSE: The federal regulation does not prohibit providers from owning housing, nor does it prohibit persons receiving HCBS from living in provider owned housing. In Iowa, there may not always be an ample supply of affordable and accessible housing for persons with disabilities. As

such, many providers have attempted to fill this void by purchasing housing for the use of the people they serve. This practice has permitted many people to live in the community who otherwise could only have been served in an institutional setting, and the department has supported the provider community for their efforts in this area. The regulation does set out some extra requirements that must be met when an individual receiving HCBS lives in a provider owned or controlled setting, in order to ensure that the setting does not have institutional qualities and that individuals rights are not unduly restricted. Those requirements include:

- A lease should be in place to provide the same protections from eviction as all tenants under landlord tenant law of state or local government. If tenant laws do not apply, a lease or written residency agreement must provide protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have freedom to furnish and decorate within the lease/agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- The setting is physically accessible to the individual

COMMENT: Vera French Community Mental Health Center is located in Davenport, Iowa, which is one of the few urban areas in Iowa. The waiting list of Section 8 Housing is now 9 years in our city. Additionally, many of the Section 8 Housing options are in unsafe neighborhoods, and many landlords are not interested in renting to persons with mental illness. To address the need for safe and affordable housing for persons with mental illness, in 1994 the Vera French Housing Corporation was established as a nonprofit to provide affordable housing options linked with appropriate supportive services for persons with severe and persistent mental illness. Currently 122 units are in Davenport and Bettendorf which include duplexes, apartment buildings, shared living homes, etc. Tenants receive a variety of services from a variety of service providers of their choosing. Several tenants receive HCBS or Habilitation services. In the Iowa transition plan, it states the member must “own or lease housing from a third party other than a provider or an affiliate of the provider”, and that “provider owned or controlled housing of any size is presumptively non-HCBS”. Even though Vera French Housing is a separate corporate entity with a separate NPI number, it is concerning as to what the definition of “affiliate” is, and if persons receiving safe, affordable housing through the Vera French Housing Corporation will now be in danger of losing services. In the federal regulations it merely speaks to “provider owned housing”, so it appears that Iowa is interpreting the regulations more strictly to the possible detriment of persons with chronic mental illness. Several options providing by VF Housing are on the same street; a good example of this is Locust St. which is over 3.5 miles long. In an urban area housing can be on the same street and be miles away from each other, so it is concerning that “multiple homes/locations on the same street” are considered to be presumptively non-HCBS settings. Additionally there are multiple service providers for persons with disabilities in the Quad Cities area. It is possible that one provider could open a home providing HCBS/Habilitation services for persons with disabilities on the same street as another provider that is also providing HCBS/Habilitation services and not be aware of each other. The same is true for apartment complexes where services are provided, as our agency does not necessarily know who is living in other apartments that may or may not be receiving HCBS/Habilitation services from other agencies.

The provider is not even necessarily aware if the “majority of residents in an apartment complex receive HCBS services”, nor should they be due to client confidentiality and HIPAA rules. It appears that many of these new guidelines are further restricting housing and service options for persons with already limited options, which I don’t believe was the intent of the new federal regulations, or of the Olmstead Act which supported a full array of service options to meet the needs of everyone, not just those that are suitable for independent living. (Beenk)

RESPONSE: Iowa’s transition plan does not state that the member must own or lease housing from a third party other than a provider or an affiliate of the provider. The settings analysis document simply classified housing that is member-owned or member-leased from a third party other than a provider or an affiliate of the provider as being in compliance with the regulation. Likewise, the transition plan does not state that provider owned or controlled housing of any size is presumptively non-HCBS, nor that multiple homes/locations on the same street are presumptively non-HCBS. The settings analysis did combine the categories of “settings that will comply with HCBS characteristics with changes” and “settings that are presumptively non-HCBS” into a single section of the grid, which caused some amount of confusion as to which setting belonged to each category. Based on the feedback we have received, we have modified the settings analysis document to break these categories out from each other. In the updated version, provider-owned or controlled housing of any size and multiple homes/locations on the same street will be included in the category of settings that will comply with HCBS characteristics with changes. In regard to the use of the term “affiliate” in the settings analysis, the intent was specifically to address situations like the one described in the comment, where a separate entity has been set up by a provider for ownership or leasing of residential property. We believe such settings still fall under the rubric of “provider owned or controlled settings” in the federal rule. If a setting could be considered not to be provider controlled simply by way of ownership by a related entity that is still part of the provider organization, it would create a setting that would not meet the intent of the regulation, and would not afford individuals receiving HCBS the full benefit of the rights and protections outlined in the regulation. However, in order to reduce any complexity that may have been introduced with the use of the term “affiliate”, we have modified the settings analysis to remove this term, and have replaced it with the verbiage “Member owns the housing, or leases housing which is not provider owned or controlled.” According to CMS guidance, provider owned or controlled settings includes those that are “owned, co-owned, and/or operated by a provider of HCBS” and as such would include housing such as described in the comment.

COMMENT: The CMS final rules issued clarification on several major areas of confusion. Specifically choice of provider in provider owned or controlled settings. The final rules clarifies “that when an individual chooses to receive HCBS 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.” We encourage Iowa DHS to adopt this language as well. (Kaestner)

COMMENT: How does provider controlled come into play with bundled services? How do you accommodate the need to bundle services, with individual choice? What if there’s no other setting available? (Seamonds)

COMMENT: What about agency owned homes? Are there providers that own homes and have other agencies provide the services? What will happen when the provider is fired?

COMMENT: Is there a requirement for us to allow other providers to provide HCBS in our building? (Salmen)

RESPONSE: CMS provided guidance that if a member receiving HCBS chooses to live in a provider controlled setting; they are choosing that provider as their residential provider. As such, a provider that owns the housing is not required to allow other providers to serve individuals in

that setting. If an individual in such a setting chooses to receive services from another provider, they may need to secure alternate housing arrangements to do so.

COMMENT: If the number doesn't matter, do you still need an Exception to Policy for a 5-bed home? (Seamonds)

RESPONSE: Yes, because there is a requirement in state law that HCBS can only be provided in an unlicensed residential setting of four or fewer beds. Under that law, any setting with five or greater beds would have to be licensed by the Department of Inspections and Appeals. However the law allows five bed homes without a license with approval from the Department of Human Services; that approval is done by requesting authorization to operate a five person home for HCBS members from the Bureau of Long Term Care.

COMMENT: Provider-owned property, duplex, give me an example of what we'll be asked to do to become compliant? (Patten)

RESPONSE: The fact that a property is provider owned, or is a duplex, does not mean that it will found to be out of compliance. The site will need to go through the assessment process, which will look at the characteristics of HCBS as set forth in the federal rule. As such, the assessment will look at the extent to which the individuals in the setting have opportunities for access to community living, including aspects such as making choices about services and their lives, being free from undue rights restrictions, and avoiding regimentation in daily activities. If the site is found to be out of compliance, the provider will be asked to submit a corrective action plan (CAP) which will detail the steps to be taken to come into compliance as well as expected timeframes. The department may accept the CAP as-is or ask for changes. After the CAP is accepted, the department will continue to check on the progress of remediation. If a setting cannot be remediated after numerous attempts, the department may impose sanctions.

III. Community Integration versus Settings with the Effect of Isolating Individuals from the Broader Community – Comments in this section center on the requirements in the federal regulations that seek to ensure that HCBS is provided in settings that are integrated in the greater community and supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS. As such, many comments do not specifically address the Iowa transition plan per se, but rather are seeking clarification or interpretation of the federal regulation.

COMMENT: Goodwill of the Great Plains was also disturbed to learn that participants in respite services will not be integrated into their surrounding community under the proposed rule. Although respite services are provided for a short period of time, it is important for all individuals to be allowed to integrate into their community at all times. We are particularly disappointed that disability-specific camps are exempted from this rule. Camps – particularly those that provide respite to children – must be integrated if we expect children to understand and appreciate the diverse abilities and personalities in all children.

Camps that segregate persons with disabilities from those without disabilities are clearly going against both the spirit and the letter of both Olmstead and the Americans with Disabilities Act and are detrimental to the positive development of individuals with and without disabilities. That the department is even considering allowing children with disabilities to be segregated from those without disabilities is a surprise to Goodwill of the Great Plains and other advocates and providers of services to individuals with disabilities. If this rule change is to be taken seriously by providers and beneficiaries alike, the Department must consider removing this exemption. I would highly suggest that if a higher level of care is necessary for a participant to engage in

such activities, the Department refer to the existing avenues for addressing such circumstances through person-based exceptions to policy. (VanderPlaats)

RESPONSE: The settings analysis made an exception for respite provided in a camp setting because it is a short-term service that does not necessarily reflect the degree of integration typical for the individual. This guidance provided with the federal regulation makes an exception for “HCBS that is permitted to be delivered in an institutional setting, such as institutional respite”. Iowa has interpreted that guidance to be applicable to respite provided in a camp setting. Any camp setting in which other HCBS services (such as Supported Community Living) are provided would still be required to be compliant with the regulation for all services provided in the setting, including respite.

COMMENT: Could you provide clarification as to how you are defining “integration”? What criteria is this measured/evaluated against?

What are the “qualities of an institution”?

In the letter it states that “CMS has moved away from defining HCBS settings based on specific locations, geography, or physical characteristics to defining them by the nature and quality of the member’s experiences”. Can you elaborate on what the “nature and quality of the member’s experiences” means and what some indicators of compliance or non-compliance might be in a certification review? (Stromer)

RESPONSE: Iowa will rely on the federal regulation and the accompanying guidance issued by CMS to define and explain these terms. In developing these aspects of the regulation, CMS considered the qualities most often articulated by persons with disabilities as key determinants of independence and community integration. To briefly summarize these qualities:

- The setting supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from options including non-disability specific settings.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

There are also additional qualities in provider owned or controlled settings:

- There must be a lease or legally enforceable agreement that provides protections from eviction processes.
- Each individual has privacy in their sleeping or living unit including entrance doors lockable by the individual, with only appropriate staff having keys; individuals sharing units have a choice of roommates; individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically accessible to the individual.

Additionally, CMS has released several guidance documents that are useful in understanding the regulation. Documents that may be of particular interest to HCBS providers would include “Regulatory Requirements for Home and Community-Based Settings” and “Guidance On Settings That Have The Effect Of Isolating Individuals Receiving HCBS From The Broader Community”. CMS has also released an extensive list of exploratory questions to assist in the assessment of residential settings, and the Department has produced a version of this document that is tailored to Iowa providers. For the full text of the federal regulation and all of

the associated guidance, please visit <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>. For documents and guidance related to the Iowa transition plan please visit <http://dhs.iowa.gov/ime/about/initiatives/HCBS>.

COMMENT: A third area of concern is the issue of settings that isolate the participants from the community. What "isolate" means and what "community" means is in my opinion somewhat subjective. I am sure that there are those who would assume that having 5 individuals with disabilities and high medical needs living in a group home would automatically lead to "isolation" from the "community". The fact is that exactly the opposite has been true for Luke in his 5 resident group home.

First of all, Luke's needs for frequent treatments for his asthma, frequent administration of various medications, the need to be in a wheelchair when not in bed, need to constant access to oxygen etc. is the basic thing that determines or limits his access to community or puts him in a situation that potentially could lead to "isolation". It is really his own physical limitations that would tend to lead to "isolation", not the fact that he lives in a group home. Despite this, since Luke has lived in his group home, he has participated in all of the following activities which the staff of the home has taken him to: Iowa Cubs baseball games, Iowa State basketball games and volleyball games, going to races in Newton, attended WWE wrestling in Des Moines, visit Bass Pro Shop in Altoona, he has been to music concerts, attended movies at a local theater, visited Ledges State Park and several city parks, attended picnics, gone on "hay rack rides" attended a Harlem Globetrotters game, gone on "walks" in his wheelchair around his home, had birthday parties and Christmas parties where he lives, and had individuals as well as various groups visit his home on a regular basis. I can assure you that he would not have been able to participate to this degree in most of these activities if he were living in any other arrangement that is currently available to him.

Concerning "isolation from the community" the fact is that Luke has a "community" primarily and precisely BECAUSE he does live in a group home. What kind of "community" would he have if he lived at home with his parents? His community would be basically his mother and I, and what ever in home providers he might have. Can you imagine what his "community" would be like if he lived in a nursing home? In the group home where he lives, Luke has four other peers. They are a big part of his community. He also has a minimum of five (and often 6 or more) different staff members to interact with day. He has at least 8 different nurses and at least 12-15 other staff members (aids/technicians) whom he interacts with on a regular basis. The staff talk to Luke and he knows many of the staff's children and spouses as well, and even some of their pets. He has regular visitors from other individuals or groups that are served by the same provider. They even have parties together with these other groups, sometimes in Luke's home and sometimes at other locations. These 20-25 providers that Luke has at his home, along with visits from his mother and I and his brother and sister and nieces and nephews, pretty much are Luke's community. Taking Luke out of his current situation and putting him in any other environment where his medical needs could be met that I can imagine, would only rob Luke of his community, not enhance it. While Luke's community may be somewhat different than the "community" of a typical 30 year old who has no physical or medical limitations or and no mental retardation issues, it is not the group home setting that makes his community different, it is his physical and medical conditions that limit or define what his community can be. In fact, it is precisely because Luke has this group home and the individuals associated with it, that he has a significant community at all. (Murrell)

COMMENT: The letter contains the following excerpt from the CMS rule: "...or any other setting that has the effect of isolating individuals...". Can you explain what criteria will be used to determine whether or not persons are being isolated? (Stromer)

RESPONSE: CMS has released guidance on settings that have the effect of isolating individuals from the community. The CMS guidance states:

“Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

Settings that isolate people receiving HCBS from the broader community may have any of the following characteristics:

- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
- People in the setting have limited, if any, interaction with the broader community.
- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

Additionally, the Department has produced a version of this document that is more specific to Iowa, which is available at: <http://dhs.iowa.gov/ime/about/initiatives/HCBS>.

COMMENT: There appears to be a false belief that those receiving any services from an “institution” have absence of community involvement. The belief appears to be based on an “all or none” mentality. Many individuals already choose to have an active community life that includes participating in church, attending local events including concerts, high school activities, and movies, going out to eat, grocery shopping, banking, volunteering, and shopping in the community. Dayhab programs (regardless of location) compliment the community life an individual chooses, providing structure, routine, variety, and social contacts, in addition to the individual’s other community involvements.

Moving dayhab and prevoc to a building located in the community, not in our “institutional” setting (which happens to be part of a broader community), can be done. By moving the physical location, have we achieved anything more than moving the physical location? I am suddenly going to have an integrated community life, because I attend a dayhab program located two blocks away from my current dayhab location in an institution? Is it truly the building location that isolates the individual? Or is the barrier attitudinal, and if so, will going to a physical location 2 blocks from my current location change that attitude?

Moving the location away from an “institutional” setting increases cost. In a combined physical location, staff, equipment and supplies can be shared. Moving it away from that setting requires staffing two settings, maintaining two buildings, providing durable medical equipment to two buildings, etc.

If the interpretation is that Dayhab settings cannot be congregate settings some issues are posed such as:

In smaller communities there are not many places to gather in the community. There would actually be much less variety than is currently offered. Those with disabilities would be spending more time at home. This is not appropriate for young adults and is much more isolating than what is currently happening. Some areas in small communities are still inaccessible to those in wheelchairs. Telling people with disabilities that they cannot congregate with others with disabilities is disrespectful! We are eliminating a valid choice that people with disabilities may want to make. The current dayhab centers should be offered as a choice after exposure to community options has taken place. Some small communities do not have areas for creative expression of Music and Art which is currently offered in a congregate setting. (Whitsell)

RESPONSE: Day Habilitation provided in a congregate site would not be automatically ruled out as an HCBS setting. However, with any 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: Participation in a dayhab program or a prevoc program is an option for individuals, it is not mandated. Isn't it time to quit looking at these as a restriction or limitation based on the location, but as an option some individual's desire?

What message is sent, when we say that it is "wrong" for disabled individuals to spend time at a place that serves other disabled individuals? Doing so needs to remain an option. Am I more likely to be isolated in a group whose abilities far exceed mine, or in a group whose abilities are a closer match to mine? (Whitsell)

RESPONSE: Neither the federal regulation nor Iowa's transition plan state that it is wrong for individuals with disabilities to spend time at a place that serves other people with disabilities. However, the regulation does clearly specify that integration refers to the greater community and not solely a community of one's peers. Individuals receiving HCBS must have the choice and opportunity to access the greater community.

COMMENT: Requiring individuals to be served in a Community Based setting sounds great, however, it has many drawbacks. Below are just a few examples:

- There are a limited number of buildings and public places to frequent that would provide an integrated setting. In rural areas, there are only so many places to go that individuals enjoy and find purpose in visiting.
- Many locations in the community are not handicap accessible because they are older buildings and thus are grandfathered and do not have to comply with ADA Rules making it very difficult and sometimes impossible to navigate.

Public buildings are not set up to allow for the toileting and personal cares that individuals with disabilities require. Most, if not all, locations that currently provide program services have facilities that have slings, lifts and other adaptive equipment that allow individuals to have Privacy and Dignity while they are assisted with personal cares. Without this equipment, it is literally impossible to provide all supports necessary for the individuals.

- Locations in the community were not constructed for daily use of wheelchairs and adaptive equipment, thus the "wear and tear" on these facilities will not be accepted by the building owners. (Whitsell)

RESPONSE: The fact that there are a limited number of places to frequent in rural areas would also be true for people in the community that do not receive Medicaid HCBS. The regulation does not require that these types of opportunities for people receiving Medicaid HCBS go beyond what is available for persons not receiving HCBS; only that individuals receiving HCBS have access to the same opportunities. Physical accessibility in the community may be challenge, but is also a challenge for people with physical disabilities who do not receive HCBS. Individuals receiving HCBS should have opportunity to face those same challenges if they so desire.

COMMENT: Individuals with certain diagnoses, specifically Autism, are ultra sensitive to their environment. When these individuals are able to be served in the correct environment, they are successful. However, it is very difficult to find that right environment in the community setting because these public places are not appropriately constructed and adapted to provide such an environment. The end result is that consumers are unable to focus and behaviors become an issue and the individual regresses in their behavior.

RESPONSE: The purpose of HCBS is to allow people to receive services in their own homes and communities rather than in institutional settings. In some situations it may be more difficult to serve people successfully in the community than in an institution, but individuals who desire to remain in the community have a right to use HCBS services and supports to achieve their desired outcomes. Some individuals may choose an institutional setting, but the state cannot pay for HCBS services delivered in the institutional setting.

COMMENT: The idea of not allowing a majority of individuals with a disability to live in an apartment building is very unreasonable. Often times these properties are Department of Housing and Urban Development (HUD) properties, thus certain criteria must be met to live in these types of apartments. It is very common that individuals with disabilities meet said criteria and qualify for this type of housing. In rural areas, there are a very limited number of these properties and it often times the only place that is affordable for the disabled individual to live. If they are not allowed to live there and receive Medicaid services, where are they going to live? (Whitsell)

- Many individuals, family members and advocates have worked for years to develop and secure funding for a wide range of community residential and vocational options for individuals. Now, funding for these options is being taken away based on some peoples' opinions that any site considered to be "congregate" is bad. If "congregate" is bad, why do we see people throughout society congregating with other people with similar interests and abilities? Over the past ten years there has been an explosion of "Senior" centers and "Senior" communities. Why? People with similar interests and abilities want to live and work and recreate together. So why is this not ok for people with disabilities? (Whitsell)

RESPONSE: Apartment complexes where the majority of residents receive HCBS are not automatically ruled out from providing HCBS. However, with any 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. 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 individual's access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: Size alone, whether large or small, does not guarantee quality of service:

- a. A home physically integrated in the community does not guarantee full integration of the people living in that home with their neighbors and community.
- b. A disabled worker in a plant with 100 non-disabled people does not guarantee full integration of this person with his/her co-workers.

Increased size can often result in cost containment, greater variety of services, enhanced quality of services, improved customer/person-centered service. Hospitals have regionalized and grown larger, schools have consolidated and grown larger, but they have done so in many cases to enhance customer service. (Whitsell)

RESPONSE: Size considerations do not guarantee quality services, nor do they guarantee integration. As such the focus of the federal regulation and Iowa's transition plan is on the member's experience. This focus includes, but is 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 individual's access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: If the requirement restricts the service location more likely prevoc will be time limited. What about those who can't go to supported employment? If Day Hab won't be in a set location, then you're eliminating choice. (Boeve)

COMMENT: Competitive "integrated" work sites are not realistically attainable by all individuals with disabilities who want and deserve the dignity of being able to earn a paycheck. Work activity centers are important to these folks who otherwise would have limited, or no opportunities for employment.

- There are not enough community jobs for people with limited job skills who are unable to meet productivity expectations of the job.
- Many entry level jobs are part-time. Statistically, if a person gets a 10 hours per week community job, the State will record this as a successful placement. Maybe so, but what happens during the other 158 hours in that person's week? Is the quality of this person's life better just because he has a community job for ten hours a week? Would an individual choose this over spending 40 hours per week with his/her friends in a work activity center?
- Many individuals, who need to develop their work skills in order to compete for community jobs, will have no opportunities to do so without work activity centers.
- Some individuals placed on community jobs, intentionally jeopardize those jobs because they are not treated well by their co-workers. They want to return to the work activity center where they know they will be treated with respect by their co-workers.

If congregate Vocational centers go away:

- Many will not be able to get a job in the community due to the severe nature of his or her disability. The other option, then, is to stay home, which can be very isolating. Individuals will lose their money earned from full-time employment as many community jobs are for 20 hours or less. When an individual earns less, there are fewer opportunities in the community for recreation, due to lack of funds. Work is a social outlet for individuals. Without going to a work center, the person with a disability may not have an opportunity to socialize. People with disabilities are not always accepted in some community work environments and may be isolated or teased. Just being in the community does not guarantee acceptance. The contract work that is done in the work centers brings in money to the community. These employers will need to make other arrangements to complete their contracts. Those in the work centers complete high quality work. This level of work may not be available by other work forces. If someone in the community loses his or her job, he or she will have to stay home until they can find a new one. This process may take longer than for those without disabilities. Currently he or she can return to the work center for further training on areas that were problematic in the job setting. Work places may have accessibility problems. Personal care assistance may need to be done in a community job setting restroom which may not have accessible facilities.

- A high percentage of people with disabilities have been subjected to “bullying” throughout their school experience. Their self-confidence and attitude about life often blossoms when they have the opportunity to live and work with others who have similar interests and needs. They can relate to and support each other and build positive relationships in a caring environment. (Whitsell)

RESPONSE: The state disagrees that integrated employment is not attainable by all persons with disabilities who desire to work in the community; with the right supports, community employment can be achieved. The regulation does not prohibit the state from offering HCBS prevocational services, and Iowa continues to offer prevocational services through the Intellectual Disability (ID) Waiver, the Brain Injury (BI) Waiver, and HCBS Habilitation Services. The state is still waiting on additional guidance from CMS on employment and day program services. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

COMMENT: Struggling with concepts of integration and segregation; how do we define that for work settings? Is community employment the purpose...is that where the employer is paying the waiver provider paying the wage? We struggle with the...concept. (Hodapp)

RESPONSE: The state is still waiting on additional guidance from CMS on employment and day program services. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted. There is increasing emphasis, at a nationwide level, on integrated community employment as a viable option for persons with disabilities. Iowa is currently working on restructuring the way employment services for persons with disabilities are delivered and reimbursed, in order to maximize community employment opportunities.

COMMENT: My son has been served by New Hope Village for the last 12 years. We are very open and supportive of all the changes. New Hope has been very open and supportive and do an excellent job. My son lives in a four-person home, he receives SCL and participates in Day Habilitation. He loves attending the Day Habilitation program. He needs the structure that this provides. He makes a lot of choices and decisions he is offered a lot of activities. He does community volunteer activities such as working in the parks, nursing homes, and the animal humane society. He shops, swims, horseback rides, bikes. We would love to have him working in the community somewhere, but we know that he cannot do that. One size does not fit all; a lot of people have unique situations. Please listen to the experts: the parents and the providers. They work extremely hard and my son is happy. (Ramthun)

COMMENT: My son has been served at New Hope Village for 14 years. I am pleased to hear that you are not restricting locations by number. My son is in a five person home; he is very active and enjoys it. He participates in the community and has a very active life. My son is part of the family of the home. They are very busy and in the community. He is very active on an integrated bowling league, dances, goes shopping, movies, and comes home twice a week. We would love to see him more but he's too busy! He goes to birthday and graduation parties. He is also in Supported Employment, he works at Pella and he has learned so many skills and has had so many opportunities. Another client moved from the campus into the home and we were all concerned that it wouldn't work, but living in the five person home has given him the opportunity to learn to get along and share cost of living, etc. I hope the consideration for the 5 person homes continues. (Baumhover)

RESPONSE: The department is pleased to hear from family members of individuals receiving HCBS who are enjoying access to, and integration in, their communities. The intent of the new regulation is to ensure that all recipients of HCBS throughout Iowa and the nation are afforded these same opportunities.

IV. Transition Plan: Settings Analysis - Comments in this section are centered on the Settings Analysis document that was released as part of Iowa's draft transition plan. The settings analysis was intended to be a general, high-level categorization of HCBS settings, not specific to any given provider or location. Initially, the department combined the categories of "settings that will comply with HCBS characteristics with changes" and "settings that are presumptively non-HCBS" into a single section of the analysis, which caused some confusion as to which setting belonged to each category. Based on the comments received, we have modified the settings analysis document to break these categories out from each other.

COMMENT: CMS is moving away from locations and to the members' experience—but in Iowa's analysis you list facility types. How do you explain the disconnect here? (Nutty)

COMMENT: The rule says it's about experiences, yet the measure is facility. You need to measure the individual, service plan, their experience. You're ultimately looking at the outcome for the member receiving services. CMS' intent appears to be completely focused on member experience—but IME continues to focus on provider location. It's concerning that providers are being evaluated based on location, which differs from the intent of the rule. The measuring stick should be based on the member, not the provider. (Chandler)

RESPONSE: The settings analysis is intended to categorize, at a high level, the settings that will require assessment. The assessment process itself will be centered on the member's experience regardless of the physical location, facility type, or size.

COMMENT: AHCA/NCAL and our members (our national office) have worked very closely with CMS over the past 2-3 years on this new regulation. We have one main question, on the Department's intent to have so many settings fall under the rebuttable presumption when the state has the option to show that many settings meet the CMS HCBS definition in our state.

Each state has the ability to determine if a setting complies with the HCBS definition, without taking the next step towards rebuttable presumption and more labor intensive work for both DHS and providers. Especially in Iowa, where our ALs licensure/certification was set up to meet the CMS requirements for a HCBS Setting (some examples: Fair Housing/Landlord Tenant law, lockable apartment doors, tenant rights same in AL regs as outlined by CMS).

We think that Iowa's ALs based on the licensure requirements in Iowa, already meet the requirements CMS outlined in the HCBS rule (see attached comments). So that ALs would be deemed to be in compliance as a HCBS setting based on the DIA review and the AL meeting the Iowa licensure/certification requirements. All ALs in Iowa meet the same requirements regardless of where they are located (next to a NF or freestanding).

I would also suggest the DHS contact DIA, as they have recently released a rewrite of IAC 481-57 (RCF licensure requirements). We believe the RCF rule rewrite should incorporate the HCBS setting requirements to ensure RCFs can also continue to be defined as a HCBS setting. I attached the draft we received by DIA.

Iowa's Assisted Living Statute and Iowa Administrative Code outline the many requirements that are consistent with the new HCBS Setting Definition. Iowa's AL programs are certified by the state on an ongoing basis to show that they meet these requirements. ICAL recommends that Iowa's assisted living programs be deemed as a HCBS setting based on Iowa's AL current DIA certification and survey requirements meeting the definition of a HCBS setting outlined by DIA in Iowa Code 231C and IAC 481- Chapters 67 & 69. (Baddeloo)

COMMENT: Our organization certainly supports your efforts to assure that Home and Community Based Services are provided in a member driven environment that facilitates choice. We also believe that Iowa's implementation of the HCBS settings rule should take into account that home and community based services are, and can be, provided in very different settings, including assisted living, independent living, HUD affordable housing, and continuing care retirement communities. These are the settings older adults and individuals with mental illness call home. What matters most is not the setting but the autonomy and self-determination of the individual receiving the services, and that they actually have a choice as to where they reside.

It would appear that Iowa's DRAFT transition plan may not reflect the intent of the final CMS rule and requires some clarification. The CMS final rule includes a "heightened scrutiny" standard for determining HCBS settings. It appears Iowa's plan includes a "rebuttable presumption" that residential care facilities, provider owned housing, and any location adjacent to an institutional setting is "presumptively not HCBS." This appears to place the full burden on the provider to prove HCBS settings compliance.

As you know, the CMS final rule moved away from defining HCBS settings based on location, geography, size and physical characteristics and instead focuses on member quality and nature of experience. However, it seems Iowa's plan retains the location and physical characteristics in the definition of HCBS settings, which seems overly restrictive.

Other states, Wyoming is an example, do not single out specific settings such as RCF's, Assisted Living, etc. but rather use characteristics that may isolate individuals from the broader community. We hope Iowa will take a similar approach.

It seems as Iowa moves forward with the State Innovations Model it is imperative that older adults and individuals with mental illness have more choices in housing and services, rather than fewer. This can be particularly true in rural areas where HCBS providers must often partner with more institutional providers.

Thank you again for the opportunity to comment. We fully support the delivery of services in a manner that facilitates individual choice. It is our hope that this rule will not inadvertently limit individual choice of living environment and service delivery. In order to maximize HCBS services and promote efficient use of resources in a more rural state like Iowa it seems best if we can provide the maximum amount of flexibility allowed under federal law to allow for creative collaborations between providers. (Strellner)

COMMENT: (regarding the section titled) "NOT – YET – with changes, settings will comply with HCBS characteristics, or; setting is presumptively non-HCBS but evidence may be presented to refute presumption."

This section assumes that all the settings listed automatically will need changes to meet the new CMS rule for HCB settings or be presumptively non HCBS. The CMS rule states: "The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. If states seek to include such settings in Medicaid HCBS programs, a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and includes input and information from the public. CMS will be issuing future guidance describing the process for the review of settings subject to heightened scrutiny through either the transition plan process (for settings already in states' HCBS programs) or the HCBS waiver review processes (for settings states seek to add to their HCBS programs)."

We should not assume that types of settings listed in this section need changes to be in compliance with the CMS setting rules.

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

We would suggest the “NOT YET – With Changes” be changed to “Sites to be assessed” as many of the sites that currently are on this list and in Iowa already meet the above qualifications. (Schwanke)

COMMENT: We believe Iowa’s implementation of the HCBS settings rule should take into account that home and community-based services 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 that older Iowans call home. What matters is not the setting but the autonomy of people receiving services.

Iowa’s proposed draft transition plan 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.” This places the full burden on the provider to prove HCBS settings compliance.

The CMS final rule moved away from defining HCBS settings based on location, geography and physical characteristics and instead uses a definition of a Medicaid member’s quality and nature of their experience.

This intent is included in clearly-stated language from CMS-authored documents, including:

Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F): “In this 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 individuals’ experiences. The home and community-based setting provisions in this final rule 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 changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law’s intention for Medicaid HCBS to provide alternatives to services provided in institutions.” (Page 1, paragraph 2).

However, Iowa's proposed transition plan retains the location and physical characteristics HCBS settings definition found in 2011's proposed federal rule. See "HCBS Settings Analysis." The document lists specific settings that are "presumed" to have institutional qualities unless proven otherwise, putting the full burden on the provider to prove they are an HCBS setting. Iowa's "HCBS Settings Analysis" lists residential care facilities, assisted living programs and any provider owned or controlled senior housing as "presumptively non-HCBS."

Iowa is including the "rebuttable presumption" language to single out individual classes of providers that is anathema to what the federal rules state. CMS removed the "rebuttable presumption" language due to public comment:

"The [early] proposed rule indicated that CMS would exercise a "rebuttable presumption" that certain settings are not home and community-based. CMS has removed this phrase from the final rule and clarified in the final rule that certain settings are presumed to have institutional characteristics and will be subjected to heightened scrutiny." (Page 3, paragraph 3)

Other states implementing transition plans, such as Wyoming and Tennessee, do not single out specific settings (RCF, assisted living, etc.) but rather use setting characteristics that may isolate individuals, such as settings that limit interaction with the broader community. The Wyoming assessment plan uses this broader language from the final federal rule:

"Settings that are Presumed to have the Qualities of an Institution:

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS." (Wyoming Department of Public Health, What's New-Bulletins, Public Notices, etc., State Plan for Assessing HCB settings Compliance, Page 2, paragraph 2).

We encourage Iowa to take a similar approach, rather than identifying specific settings. LeadingAge Iowa recommends replacing the settings-specific language in the HCBS Settings Analysis with something similar to the language used in the Wyoming plan.

CMS also has on its 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).

LeadingAge Iowa 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.

As Iowa moves forward with its State Innovations Model (SIM) 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. (Nutt)

COMMENT: Setting Requirements: In the commentary written in the final rule it states specifically that the rule does not provide "one singular definition" in describing a home and community-based setting, but instead describes, "the qualities that apply in determining whether

a setting is community-based.” For lowans with disabilities, how these qualities are defined will be key in ensuring that each individual has access to truly integrated community settings.

CMS further expressly declined to set a size limit but made the following comment: “The focus should be on the experience of the individual in the setting.”

IACP strongly urges Iowa Medicaid Enterprise to focus on the experience of the individuals when determining if a setting is community-based, rather than relying upon a set of pre-determined numerical or geographic criteria. Utilizing pre-determined criteria will not enhance, but will deter individuals from pursuing the benefits of living in the community. Iowa, due to a variety of geographical and economic factors, has a multitude of settings in which services are provided. Much of this is due to Iowa’s culturally distinct rural communities and the well-documented shortages in safe, affordable and accessible housing.

IACP supports utilizing the following quality indicators when assessing an individual’s experience to ensure that they are truly living in a home and community based setting of their choice.

1. The individual has access to the greater community
2. The individual has access to engage in community life and activities
3. The individual has the ability to control personal resources
4. The individual is given the ability to choose from available options a setting to live in based on their needs, preferences and resources available to them.
5. The individual will have privacy, dignity and respect.
6. The individual has the opportunity to exercise initiative, autonomy and independence in making life choices.
7. The individual is given ample information to make informed decisions about the services they receive and who provides those services.
8. The individual has the same responsibilities and protections regarding landlord/tenant relationships when entering into these types of agreements/relationships.

IME’s draft plan for transition and analysis focuses on provider setting as the majority of the benchmarks to determine compliance. And again in IME’s initial analysis of the service settings, characteristics of the setting were utilized to determine compliance rather than focusing on member experience and outcomes.

Sanctions being considered are based upon the provider setting not the experience or outcome for the individual as clearly outlined in the CMS final rule and commentary. IACP strongly urges that all measurement of success for this transition be focused on the Medicaid member and their experience. Including the success of the provider during this transition.
(Chandler)

RESPONSE: It was not Iowa’s intent to have a large number of settings fall under the rebuttable presumption of noncompliance. The initial settings analysis did combine the categories of “settings that will comply with HCBS characteristics with changes” and “settings that are presumptively non-HCBS” into a single section of the grid, which caused some amount of confusion as to which setting belonged to each category. Based on the comments we have received, we have modified the settings analysis document to break these categories out from each other. In the updated version, residential care facilities, assisted living programs, and provider owned housing will be included in the category of settings that will comply with HCBS characteristics with changes, and not in the category of presumptively non-HCBS. Iowa’s transition plan outlines a process of assessment that will be based on examining the characteristics of HCBS rather than relying on size, physical structure, or geography. 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; whether the person has a choice

of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: Luke has lived in a group home for medically fragile individuals for the past seven years. Because of his total dependence on others for all of his needs, and his severely fragile medical condition, there are very few options available for meeting his needs. If it were not for the home where he has lived for the past 7 years, what other options would there be for his care? Frankly none that would even come close to serving his needs like the home where he currently lives. Other options would include living at home with us his parents. We are both over 60 years old and have physical limitations that would significantly impact our ability to physically take care of him (such as bathing, transfers from bed to wheelchair and back etc.) In addition, because of the fact that Luke requires 24 hour a day 7 day a week care, even with in home aid available through an outside agencies covered by HCBS it would require us to provided Luke's cares for at least an average of 12 or more hours per day. It is not practical for us as his parents to do that for an extended time. Other options could conceivably include state run facilities like Woodward or a nursing home. Clearly neither of these settings would provide appropriate care for our son Luke or others with needs like his.

The home where he currently lives, as I have said, is a 5 bed home. One of the reasons that this type of setting was chosen by the provider was that the costs of providing care for individuals with high medical needs like Luke's requires a high level of staffing. Luke's medical conditions require 24 hour a day nursing care. The nurse does not have to do all his cares but a nurse's presence 24 hours a day is required. Where Luke now lives, there is at least one nurse present in the home at all times, and sometimes more. There is always a minimum of two and sometimes three total staff available to meet the needs of the 5 residents. The cost of staffing is a major economic factor in being able to provide the needed services. To try to do this in a setting of less that 5 residents per home could have a serious negative impact on the ability of the provider to provide adequate staffing and still meet the needs of those being served. If the home consisted of only four residents per home, I am sure that it would still require the same number of staff as they now have, but that overhead would be shared by only 4 rather than 5 individuals being served and therefore increase the cost per person. With the limits on reimbursements provided by HBCS I have serious doubts that it would be fiscally possible for the provider to provide the level of care that Luke has had and will continue to need, if those services had to be provided in a four person setting rather than a 5 person setting. (Murrell)

COMMENT: Why are 5 bedroom homes considered no longer acceptable? My daughter, who has multiple health conditions and severe cerebral palsy and mental retardation just moved into a 5 bedroom home in West Des Moines. She receives more care and attention, better quality of life, public outings and social interaction than she has ever gotten in a "facility" – even the very good facility called ChildServe in Johnston. When we had to move her to an adult facility, the only alternative available to us was a nursing home. There were no residents my daughter's age; the staffing was always short; and they didn't even attempt to engage her in social activities or try to retain the skills she had using a speech device.

In her new group home, five residents share the cost of utilities and services, which is the only way they could ever hope to live independently in a community setting. Many of these clients are not able to work, even in supported settings, because of their combination of disabilities. It would be economically impossible for these individuals to live in an environment with fewer housemates due to the high cost of living, without even taking into account their multiple medical needs. My daughter is so much happier than she ever was in a nursing home or facility setting, and is now able to take her nutrition by actually eating by mouth as opposed to getting all of her nutritional needs via g-tube.

This policy seems akin to turning the calendar back to the 1960's when the only choices open to families with a disabled individual were institutions. It has finally become evident to our

society that people with intellectual disabilities and medically fragile individuals deserve the same rights and privileges that are the norm for the general population. Please don't make our family members go back to institutional services that are woefully inadequate! (Bustad)

RESPONSE: Five-person homes are not automatically excluded from participation in HCBS. Each location and situation is different, and the assessment to determine compliance will be centered on the member experience, rather than relying on size or other physical characteristics.

COMMENT: If a person already is in Elderly Waiver and in a Senior living facility, do the payments continue as before, until the assessment is done? Or is payment delayed? We are applying for mother to get on the Elderly Waiver, will her application be processed as normal? (Blessman)

RESPONSE: Processing of member applications for HCBS programs will not be affected. Payment to properly enrolled HCBS providers for services rendered will not be delayed prior to assessing for compliance.

COMMENT: Can you please explain the rule pertaining to no payment for services provided in a provider's office? (Johnson)

RESPONSE: Current rules in Iowa Administrative Code prohibit payment for HCBS services provided in the provider's office; as such this was included in the noncompliant settings section of the settings analysis. However, because this requirement is not specifically related to the federal regulation, it has been removed from the updated version of the settings analysis. The requirement remains in place in the Iowa administrative rules, and will continue to be enforced as in the past.

COMMENT: Are you saying these rules will also apply to Habilitation? (Chandler)

RESPONSE: Yes, the regulations also apply to the 1915(i) HCBS Habilitation Services program.

COMMENT: In a small rural community, our agency is part of that community. For Day Habilitation services, I've been hearing 100% of it has to be in the community there are only so many places to access in the community in a small rural town. People will be sitting at home. It limits options for people who don't have that to start with, such as making enclave and workshops no longer available. we have a hard time finding staff for residential let alone employment supports. Choices have been regulated away from folks. (Feldman)

COMMENT: Day Habilitation and Prevocational – the rule says must be at integrated settings. The rule is clear. I had a call from a provider with 180 people in their day program; they do not have 180 community people to provide 1:1 integration, and, how do they pay for that? The burden is on the provider. This is the difficult thing for compliance. (Chandler)

RESPONSE: We are still awaiting guidance from CMS in regard to day program settings. We believe that it is premature to conclude that day program services will not be allowed in congregate settings. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

COMMENT: We operate an RCF-PMI on the Cherokee Mental Health Institute campus. Are we automatically excluded (from being compliant)? (Porter)

RESPONSE: The setting is not automatically excluded, but it does fall into the category of settings presumed not to be compliant, and may have to go through the CMS heightened scrutiny process if the assessment process determines that it meets the requirements for HCBS.

COMMENT: Farmsteads and 5-bed homes are listed in the “not yet” category. Does it mean that CMS will not allow 5 person homes or for people to reside on farms? (Portz)

RESPONSE: The settings analysis is referring to those five-bed residential care facilities (RCFs) that converted to five-person HCBS homes in the past. The concern is that there may be increased risk that the institutional qualities from the RCF carried over to the HCBS setting. The term “farmsteads” in the initial settings analysis did not refer to family-owned farms or farms in general; it referred to disability-specific farm communities. Such communities are usually provider controlled settings where most or all services are provided on the farm, where individuals have little access to the community, and live and work primarily with other persons with disabilities. In order to prevent any confusion over terminology, the settings analysis has been changed to use the term “Disability-specific farm communities” rather than “farmsteads”.

COMMENT: By virtue of assistive living, community integration is basic in what we do. I wonder why assisted living is considered in the “Not Yet” category. (Wiederin)

RESPONSE: Because many assisted living settings in Iowa are located on the same campus as nursing facilities, or are physically attached to nursing facilities, there is increased risk that they may have the qualities of an institution. However, CMS has provided additional guidance on Continuing Care Retirement Communities (CCRCs), which states that “CCRCs do not raise the same concerns around isolation...particularly since CCRCs typically include residents who live independently in addition to those who receive HCBS.” It should be noted that inclusion in the “not yet” category of the settings analysis does not mean that HCBS will be prohibited in that setting. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: My brother with Down Syndrome has been served for 22 years at New Hope Village. Fabulous services. He started on the campus and moved to a community home; four years ago he had three homes to choose from and he chose to live in a duplex. When I see that duplexes are not meeting the requirements of HCBS, my brother wants to stay in his chosen home; as a family member, if he can no longer live there it will be an issue. He works, he socializes, and he has every opportunity to participate in the community. He wants to stay there even though it’s next door to others receiving services. He works in the community but seeks his peers for social activity when he gets home. As a family member what things am I supposed to look at? (Jansen)

COMMENT: Why has Iowa identified Adult Day Care as one of the “Not Yet” settings? (Seamonds)

RESPONSE: Duplexes and adult day care are listed in the settings analysis category of “not yet compliant” because with settings that congregate 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. However, just because a person lives in a duplex or attends adult day care, does not mean that location is out of compliance or that the person will have to move. Inclusion in the “not yet” category of the settings analysis does not mean that HCBS will be prohibited in that setting. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high-level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: In a given apartment complex, what percentage of units could be occupied by disabled individuals before it would not be considered integrated? (Kaestner)

RESPONSE: There is not a set number or percentage. Apartment complexes where the majority of residents receive HCBS are listed in the settings analysis category of “not yet compliant” because with settings that congregate 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. Inclusion in the “not yet” category of the settings analysis does not mean that HCBS will be prohibited in that setting. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: Is a day habilitation location at a provider office building in the community prohibited? We have sheltered work providers doing day habilitation at the facility, what about that? (Anderson-Noel)

RESPONSE: We are still waiting on additional guidance from CMS on day program services such as day habilitation. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

COMMENT: Will members that live in homes right next to hospitals or institution be impacted? This may be more applicable to small towns or rural settings. (Bradke)

RESPONSE: It is possible that there will be an impact on this type of setting. Under the federal regulation, settings adjacent to public institutions are presumed non-HCBS. If the state finds that such a setting does comply with the regulations, evidence can be submitted to CMS for a heightened scrutiny review and a final decision from CMS. Iowa's initial settings analysis used one combined category for settings that were presumed non-HCBS and settings that could become compliant with changes. In order to clarify the difference between these categories, the settings analysis document has been revised to reflect this difference. The vast majority of settings in Iowa will not be presumed non-HCBS and will not require a heightened scrutiny review.

COMMENT: What is an "affiliate" of a provider? Having the word "affiliate" in the State's language is more restrictive than the federal regulations because "affiliate" is not defined in the regulations. Vera French has 3 separate corporations, a housing corporation, a mental health center, and a community provider; are these considered "affiliates"? Can "affiliate" be deleted from Iowa's Plan, please? (Kiser-Willey and Armknecht)

RESPONSE: The intent of using the term "affiliate" was specifically to address situations like the one described in the comment, where a separate entity has been set up by a provider for ownership or leasing of residential property. We believe such settings still fall under the rubric of "provider owned or controlled settings" in the federal rule. If a setting could be considered not to be provider controlled simply by way of ownership by a related entity that is still part of the provider organization, it would create a loophole that would not meet the intent of the regulation, and would not afford individuals receiving HCBS the full benefit of the rights and protections outlined in the regulation. However, in order to reduce any complexity that may have been introduced with the use of the term "affiliate", we have modified the settings analysis to remove this term, and have replaced it with the verbiage "Member owns the housing, or leases housing which is not provider owned or controlled." According to CMS guidance, provider owned or controlled settings includes those that are "owned, co-owned, and/or operated by a provider of HCBS" and as such would include housing such as described in the comment.

COMMENT: Federal Rule relating to 1915c waivers may disallow our supervised apartment program setting. There may be questions about the setting being integrated in and supporting full access to the greater community. While on the face of it, this may look like a "disability specific complex", however, further exploration shows a recovery focused, behavioral health service option that has been a part of the community since 1983.

The purpose of my comments are two-fold:

1. To Make the Department aware of an existing supervised apartment program located in Des Moines and its contribution to the mental health community.
2. Impact on community if the program does not meet changes to proposed rule.

Mainstream Living currently owns and operates 2 supervised apartment programs in Polk County: Des Moines. This program supports 59 individuals with chronic mental illness.

Demographics and service summary;

- 85% of the tenants receive habilitation funding.
- Individuals sign a lease, the lease is in compliance with all Local and State Landlord Tenant rules.
- Individuals are free to come and go as they please and have full access to the community.
- Apartment buildings are well-lit, secure and safe
- Affordable units. Most of our tenants would not meet landlord qualifications to otherwise rent safe and affordable units due to low income, bad credit, eviction history, or criminal backgrounds. Our program allows tenants to build a positive rental history.

- Staff and service recipients work on future planning within the first 30 days. the program is designed to be transitional living for some a long-term for others a long-term option.
- Staff support individuals based on personally identified goals and on-going supports; these activities may include; independent living skills, crisis management and support, appointment management and daily well-being checks to assure safety. Client driven treatment planning occurs, at minimum, annually.
- Medication support and medical treatment services are available and based on preference and need. Over 90% of the individuals in this program receive daily, staff-administered medications from on-site staff because, to date, they have been unable to master the skill to self-administer medications safely or accurately. The remaining individuals are self-medicating and receive daily to a two-week supply of medications, depending on their skills and reliability. This service in particular help keep individuals stable and able to live in the community.
- 50% of service recipients have a history of co-occurring (substance abuse and mental illness) disorders. Of those individuals 50% are in an active state of substance abuse. A substance abuse counselor is available, on site, for individual support.
- 20% of the individuals in the program have been incarcerated, of those, 50% are currently on probation
- Referrals to the program come from Integrated Health Homes, hospitals, criminal justice and in-patient substance abuse treatment programs. Referrals are steady and we always have a waiting list, indicating a community need.

Impact on community if the program closes:

1. This service model provides a cost-effective recovery-oriented alternative for persons with severe and persistent mental illness. If our program didn't exist in-patient psychiatric hospitalizations, homeless and jail days would increase.
2. We believe the daily rate to provide services to these individuals will increase dramatically: 50% of individuals that we serve will require small 24 hour staffed homes, the remainder will require hourly daily services. This will result in increased costs to the State.
3. As part of the Polk County Housing Trust Fund consortium of providers, I am aware of the need for safe, affordable low-income housing options. If our program no longer exists, the Des Moines community will lose 29 double occupancy units for this low income population. (Wingfield)

RESPONSE: Supervised Living Apartments would not be automatically ruled out as an HCBS setting. However, with any 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. However, just because a person lives in a supervised apartment setting, does not mean that location is out of compliance or that the person will have to move. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high-level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: Easter Seals Iowa believes in community based services. We offer services and supports at our camp location that support persons to live in the community. The services and supports provided allow families to work and rest while their adult and/or child with a disability has the opportunity to participate in activities that promote independence, wellness, health and social development.

We believe that the current grid provided may not allow for enough flexibility to meet the individual's unique needs, in the most appropriate environment. Many of the persons receiving services at our camp rely on those services for skill building, supervision and personal supports. We have designed our programs to promote choice, independence and flexibility. An institution should not be defined by location but rather by state of mind and quality of services provided. We believe that the method of service delivery is far more important than location. Many of our programs prevent persons from the isolation of sitting at home watching TV, losing skills, and remaining in more restrictive environments. Removing services and supports that occur in an environment, that allows for flexibility will likely result in loss of independence and choice for persons with disabilities. Removing those services and supports from families will surely result in loss of job, increased institutionalization and breakdown of families.

Easter Seals Iowa supports a grid that holistically assesses service provision versus a grid that solely defines the environment of the where the services are provided. (Nielsen)

RESPONSE: Iowa's transition plan and settings analysis does not remove services and supports in the camp setting. The settings analysis did combine the categories of "settings that will comply with HCBS characteristics with changes" and "settings that are presumptively non-HCBS" into a single section of the grid, which caused some amount of confusion as to which setting belonged to each category. Based on the comments we have received, we have modified the settings analysis document to break these categories out from each other. In the updated version, disability-specific camp settings will be included in the category of settings that will comply with HCBS characteristics with changes. 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. Please note that the settings analysis makes an exception for respite provided in a camp setting because it is a short-term service that does not necessarily reflect the degree of integration typical for the individual. However, any camp setting in which other HCBS services (such as Supported Community Living) are provided would still be required to be compliant with the regulation for all services provided in the setting, including respite.

COMMENT: In the setting analysis document, we would recommend the following:

- Prevocational programs that are time-limited and in integrated community settings should be considered to be fully compliant with HCBS characteristics.
- Provider and provider-Affiliated housing that is integrated into the community where the individual served has a lease agreement should be considered to be fully compliant with HCBS characteristics. Landlords do not see individuals with criminal histories and no or poor rental histories as viable applicants, so it is these settings that are a first step to establishing a life in the community.
- Farmsteads where person-centered plans have identified the individual's preference to live in the country in single family houses should be considered to be fully compliant with HCBS characteristics. (Walters Crammond)

RESPONSE: The settings listed in the settings analysis are meant to be a general, high-level categorization of the possible HCBS settings in the state. The department does acknowledge that many specific locations within these settings will already be in compliance; however, there

may be locations that are not in compliance as well. As such, all locations within these settings 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: If an assisted living is next door to a nursing facility, will we have to figure out how to fix that? (Lukes)

RESPONSE: When an assisted living program is located on the same campus as nursing facility, or is physically attached to nursing facility, there is increased risk that the assisted living may have the qualities of an institution. However, inclusion in the “not yet” category of the settings analysis does not mean that HCBS will be prohibited in that setting. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time. Additionally, CMS has provided guidance on Continuing Care Retirement Communities (CCRCs), which states that “CCRCs do not raise the same concerns around isolation...particularly since CCRCs typically include residents who live independently in addition to those who receive HCBS.”

COMMENT: What is driving the changes and how is it better for a senior citizen in Residential care? Is it cost prohibitive, or will Medicaid pay the costs? (Shaffer)

RESPONSE: The intent of the federal regulation is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals who do not receive HCBS. The regulations also aim to ensure that individuals have a free choice of where they live and who provides services to them, as well as ensuring that individual rights are not restricted. While Medicaid HCBS has never been allowed in institutional settings, these new regulations clarify that HCBS will not be allowed in any settings that have the qualities of an institution. We do not believe that the changes are cost-prohibitive. Serving people in smaller settings can have greater cost than in congregate settings due to the need for lower staffing ratios (more staff per individual), but there are often greater infrastructure costs with larger congregate settings. Medicaid will continue to pay for HCBS services and supports delivered in settings that are compliant with the regulation.

COMMENT: Currently there are waiver services provided within an RCF setting, when will that no longer be okay? (Glenn)

RESPONSE: Iowa's transition plan does not prohibit HCBS services provided in an RCF. Many RCFs in Iowa are small and are integrated into communities, but others are larger and isolated from communities. With any settings that congregate 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. However, inclusion in the "not yet" category of the settings analysis does not mean that HCBS will be prohibited in that setting. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

COMMENT: In addition, we suggest the following be eliminated from this list because we do not believe they meet the criteria listed in the final rules as having the effect of isolating people receiving Medicaid funded services from the boarder community.

1. Provider owned or controlled housing of any size. The CMS requirements for provider owned or controlled housing can be addressed with minor changes to the IAC to required leases or other legally enforceable agreement providing similar protections. The rest of the requirements are already part of IAC 481-78. Many provider settings already utilize leases.
2. Multiple homes/locations on the same street (including duplexes and multiplexes) – This in effect says that if you have a disability and need home and community based services you have to check and make sure that no one else living on your street needs these services – because if they do – one of you is going to have to move.
3. Farmsteads – Really if you have a disability in Iowa and live on a farm you are isolated from the boarder community? Our state was built on farmsteads and quite frankly this is offensive to those of us who live in rural communities.
4. Day Program settings that isolate participants from the greater community. CMS has stated that they will be providing further guidance on how these rules apply to non-residential settings, we suggest that Iowa's plan not include these settings but rather acknowledges that these settings will be added to the plan when CMS provides further guidance. (Schwanke)

RESPONSE: It is correct that changes to the Iowa Administrative Code will need to occur, and many of the requirements are already outlined in state administrative rules. However, the state not only needs to assure that our rules are in compliance, but that the requirements are being met in practice, to assure that individuals receiving HCBS are afforded the rights and protections provided by the regulation. Multiple homes/locations on the same street are listed in the settings analysis category of "not yet compliant" because with settings that congregate 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. However, just because a person lives on a street with other individuals receiving HCBS does not mean that location is out of compliance or that the person will have to move. As such, provider owned and controlled housing and multiple homes/locations on the same street will remain in the settings analysis as settings that can be compliant with changes, and specific locations within those settings will be subject to the assessment process. In regard to the term "farmsteads", the use of this term in the initial settings analysis did not refer to

family-owned farms or farms in general; it referred to disability-specific farm communities. Such communities are usually provider controlled settings where most or all services are provided on the farm, where individuals have little access to the community, and live and work primarily with other persons with disabilities. In order to prevent any confusion over terminology, the settings analysis has been changed to use the term “Disability-specific farm communities” rather than “farmsteads”. The setting described as “day program settings that isolate participants from the greater community” has been removed in the revised version of the settings analysis because the revised version includes “Settings that isolate participants from the broader community” under the presumed non-HCBS category, which is inclusive of this.

COMMENT: Provider offices—does that mean Day Hab services can’t take place in the same building, or not in my office space? (Dunshee)

COMMENT: What is a campus setting? I have a retirement community that has 20% of the community’s population in my campus. (Baddeloo)

COMMENT: (regarding the section titled) “NO – Settings do not comply with HCBS Characteristics”: CMS rule excludes nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings. It does not exclude services provided in a campus setting or services provided in provider offices. We suggest that these settings be moved to the NOT YET section of this plan. (Schwanke)

RESPONSE: Current rules in Iowa Administrative Code prohibit payment for HCBS services provided in the provider’s office; as such this was included in the noncompliant section of the settings analysis. However, because this requirement is not specifically related to the federal regulation, it has been removed from the updated version of the settings analysis. The requirement remains in place in the administrative rules, and will continue to be enforced as in the past. We have also removed the reference to campus settings in the noncompliant section of the settings analysis, as this is not specifically set forth in the federal rule. However, services provided on a campus or other large congregate settings are at increased risk that the location may have the qualities of an institution and may require extensive remediation to come into compliance.

COMMENT: Regarding duplexes: is it OK for a provider to provide services in both sides of one duplex? How about multiple buildings on the same street? (Stromer)

COMMENT: Under the “NOT YET” section of the Iowa HCBS Settings Analysis: “Multiple homes locations on the same street (including duplexes and multiplexes).” Does this mean that persons with disabilities cannot be served in both sides of one duplex, even if said duplex is the only HCBS home on the street?

“Day program settings attached to a facility” Can you clarify what “attached” and “facility” mean?
“Day program settings that isolate participants from the greater community” Can you explain what criteria will be used to determine whether or not persons are being isolated? (Stromer)

RESPONSE: Duplexes and multiple homes on the same street are not prohibited from providing HCBS. They are listed in the settings analysis category of “not yet compliant” because with settings that congregate 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. However, just because a person lives in a duplex or on a street with other individuals receiving HCBS does not mean that location is out of compliance or that the person will have to move. All locations where HCBS is provided in the state will be assessed for compliance with the regulations, regardless of the high-level categorization done in the settings analysis. 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; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time. Likewise, day programs which are co-located in a building with other disability-specific services or provider offices are also at increased risk of having the qualities of an institution, but will be assessed on the characteristics of HCBS as well. The setting described as "day program settings that isolate participants from the greater community" has been removed in the revised version of the settings analysis because the revised version includes "Settings that isolate participants from the broader community" under the presumed non-HCBS category, which is inclusive of this.

COMMENT: I am writing to express my displeasure with the changes proposed. Our 27 year old daughter lived at home with us until she was 15 when we could no longer properly care for her at home. Luckily she was accepted at child serve in Johnston where she lived until aging out at 22. We struggled at that time to find appropriate housing and ended up placing her in a nursing facility where she lived for 4 years before being accepted into a Mainstream living new facility in West Des Moines. The nursing facility was not the proper setting for her and we were extremely pleased to be selected to have her reside at the new mainstream home and we know how fortunate we are. There is an alarming need for these homes and any changes to take them away would be disastrous. Please consider all of us in these situations when deciding the future of them. (Bustad)

RESPONSE: Neither the federal regulations nor the Iowa transition plan are intended to take away any HCBS homes, or to remove access to HCBS services and supports. The intent of the federal regulation is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals who do not receive HCBS. The regulations also aim to ensure that individuals have a free choice of where they live and who provides services to them, as well as ensuring that individual rights are not restricted.

COMMENT: My question is in regards to the RCF community being located near a hospital, will there be a mileage radius that is considered or does the ruling state that it can't be across the street. We have a hospital in close proximity but not across the street. (Mattas)

RESPONSE: The regulation classifies settings that are "on the grounds of or adjacent to a public institution" as being presumed to have the qualities of an institution. We believe this would include settings that are next door to, or across the street from a public institution. It is important to note that the regulation specifies a "public" institution, which would include hospitals that are publicly owned such as a county hospital or a university hospital, but would not include privately owned hospitals; however, any setting that discourages integration in the broader community, whether public or private, may require remediation or heightened scrutiny.

V. Transition Plan: Assessment - Comments in this section are centered on the assessment portion of the draft transition plan, excluding the settings analysis which is addressed in the previous section of this document.

COMMENT: On the Transition Plan, page 1, action item #5 it states “State will use GIS to analyze potentially isolating locations of provider sites and congregate member living.” Can you explain what criteria will be used to determine whether or not a site is “potentially isolating”? (Stromer)

RESPONSE: The purpose of the GIS analysis is to determine areas where there may be a high concentration of individuals receiving HCBS. This alone does not indicate that a setting is potentially isolating, but only indicates areas where further assessment may be warranted. As such, we have modified this item to read “State will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentration of HCBS”.

COMMENT: On the Transition Plan, under Sources it lists a “Modified” version of the “Exploratory Questions to Assist States in Assessment of Residential Settings”. Could we see the modified version that you are working from? The only version that we have is the version from CMS. (Stromer)

RESPONSE: The version that has been modified for Iowa is titled “Iowa Exploratory Questions for Assessment of Home and Community-Based Services (HCBS) Residential Settings”, and is posted on the IME website at: <http://dhs.iowa.gov/ime/about/initiatives/HCBS>.

COMMENT: I am presenting these comments and concerns on behalf of two established Residential Care Facilities (RCFs), Emeritus at Silver Pines in Cedar Rapids and Emeritus at Northpark Place in Sioux City. 16 of the state’s most vulnerable citizens currently make their home at one of the aforementioned communities. Emeritus at Silver Pines is currently unable to renew their contract to provide and be reimbursed for services under the Individual Consumer Direct Attendant Care (I-CDAC) Waiver program and I fear Emeritus at Northpark Place will eventually lose their contract or be unable to renew.

I am advocating for RCFs to be included in the final transition plan provided appropriate licensure and certifications are in place and after a state review of the facility. If RCFs are left out of the final transition plan, as they currently are per the rule finalized 1/1/14 and made effective 3/17/14 for Iowa HCBS settings, it would be the immediate detriment of the citizens currently living at these two communities, some of whom have made the community their home for several years. Emeritus at Silver Pines and Emeritus at Northpark Place currently adhere to all expectations for settings in which HCBS can be provided as set forth in the April 2014 “Transition Plan Bulletin.”

Specifically, Emeritus at Silver Pines and Emeritus at Northpark Place:

1. Was selected by the individual from options that include non-disability specific settings and options for private units;
2. Provides private apartments for all HCBS residents including, but not limited to having entrance doors which can be locked by the resident with only appropriate staff having keys and allowing residents the freedom to furnish and decorate their apartment;
3. Gives residents a choice regarding the services they receive and by whom the services are provided;
4. Allows residents the freedom and support to control their own schedule and activities, including, but not limited to having access to food at any time and having visitors of their choosing at any time;
5. Ensures the individual right to privacy, dignity, and respect, and freedom from coercion and restraint;
6. Optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom they interact; and,

7. Has a written residency agreement in place with each HCBS participant providing protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.

As Emeritus at Silver Pines and Emeritus at Northpark Place already meet all of these expectations, neither community should be presumed to be “institutional in nature;” thus, it is my firm belief HCBS services should be allowed to continue in the settings these residents have been comfortably living under.

I certainly respect the published purpose of these new regulations, to ensure that individuals receive Medicaid Home and Community Based Services (HCBS) in settings that are integrated in and support full access to the greater community. Additionally I fully support to the aim of these regulations to ensure that citizens have a free choice of where they live and who provides services to them, and well as ensuring that individual rights are not restricted. The I-CDAC Waiver residents that currently make Emeritus at Silver Pines or Emeritus at Northpark Place their home have done so by choice and it would be in the best interests of their personal well-being if they were allowed to remain there versus undergoing the uncertainty and stresses of finding a new place to live in presumptively a short period of time with, possibly, very limited options. (Lahr)

RESPONSE: In regard to the statement in the first paragraph about this provider being unable to renew their contract to provide Consumer Direct Attendant Care under the Elderly Waiver; this is an issue that centers on licensure and is unrelated to the HCBS Settings regulation or Iowa’s transition plan. The provider should work with the IME to become enrolled in the correct provider category. In regard to the additional comments about residential care facilities (RCFs) being included in the final transition plan; Iowa’s transition plan does not exclude RCFs from providing HCBS. HCBS that is delivered in an RCF setting will need to conform to the regulation to ensure that individuals receiving HCBS are integrated in and have full access to the greater community.

COMMENT: The 1st 3 action items have proposed end dates prior to the end of the public comment period. As referenced in the white paper, states are required to submit input from the public in the development of the transition plan. This is not possible with the first two action steps as they ended prior to the public comment period and limited in the third as the public comment period extends past its end date. We propose that at minimum the end dates for these action steps extend past the public comment period. (Strellner)

RESPONSE: The end dates in the draft transition plan referred to the draft version of the settings analysis which was published with the draft version of the transition plan for public comment. Both the transition plan and the settings analysis are being modified based on public comments received before submission of a final version to CMS. The three items mentioned in the comment have been merged into one item titled “Settings Analysis” in order to clarify that these steps are all related to the development of the settings analysis document. The end date for this item has also been changed to July 31, 2014 to encompass the public comment period and time to make revisions.

COMMENT: Question why nine of the 9 of the 12 actions steps proposed start dates are before input to the plan is due. What is the point of asking for input to a process that has already started? (Strellner)

RESPONSE: The federal regulation and the guidance published by CMS require the state to produce a transition plan including a settings analysis for public comment, as such these action items must be completed prior to the public comment period. However, the transition plan and settings analysis were in draft form and have been modified based on the public comments received. Other action items involved internal processes within the IME where internal

discussions and planning could be done prior to public comment, but still allow for changes based on the comment process.

COMMENT: The Assessment section of the HCBS Settings Summary indicates that States are required to review and analyze all settings in which HCBS are delivered and settings in which individuals receiving Medicaid HCBS services reside. Will residential care and treatment settings be assessed, if residents are not receiving HCBS services? (Strellner)

RESPONSE: The regulation only pertains to individuals receiving HCBS; the state will not assess settings where HCBS is not provided.

COMMENT: Will our waiver specialist visit us prior to April 2015? Currently we receive non-assessment visits throughout the year. (Byers)

COMMENT: Our affiliates just went through 3-year certification. Will we have to wait 3 years before we get feedback on this? (Brecht)

COMMENT: What happens between now and the assessment? (Lahr)

COMMENT: Will we have to do the assessment process annually? (Wiederin)

RESPONSE: Iowa is taking a multifaceted approach to the assessment process, so even though another HCBS certification review may not be done for a few years, providers will get results from other activities in the assessment process such as the annual Provider Quality Management Self-Assessment process, the Iowa Participant Experience Survey, and from any other types of reviews that may be done by the HCBS Quality Unit, for example any time an HCBS Specialist is on-site for a complaint investigation, there could also be findings related to the settings regulation. We are also providing tools that will assist providers in looking at their own settings, such as the Iowa-modified version of the exploratory questions document that was published by CMS. Providers are also encouraged to contact the HCBS specialist in their area with any questions that may arise. A list of the HCBS specialist by county is available at: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts>.

COMMENT: If we have a question on what may be one way or another, how do we get an answer and how do we get that quickly? (Seamonds)

RESPONSE: We encourage providers to contact the HCBS Specialist in their area; they can provide technical assistance. Current contact information for the HCBS Specialists is available at: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts>.

COMMENT: What is the impact on the assisted living community? Is there no application or special assessment process for them, or will it be an onsite review? (Hogensen)

RESPONSE: Assisted living programs where HCBS is provided will go through the same assessment process as all other HCBS settings. Providers should begin analyzing their own settings and revising policies and practices as needed, and are encouraged to contact the HCBS Specialist in their area if technical assistance is needed.

COMMENT: Will providers have input on changes to the Provider Quality Management Self-Assessment? It would be important for us to have a feedback opportunity so we can be proactive. (Armenknect)

RESPONSE: The changes to the self-assessment form will closely follow the requirements in the federal regulation. However, the department does plan to make a draft version available for provider review before changes are finalized.

COMMENT: Will the individual performing residential assessments also be performing day service assessments at the same time? (Sargent)

RESPONSE: It may vary depending on when the provider's certification for each service is due. However, anytime an HCBS Specialist with the HCBS Quality Oversight Unit is onsite, there could be findings related to an HCBS settings issue.

COMMENT: Will providers receive advance notice of assessments?

RESPONSE: Assessments will be part of the ongoing HCBS review cycles and will be included in the annual self-assessments. Providers are encouraged to start reviewing their own policies and procedures now so that they can initiate needed actions even before a formal assessment has been completed. Providers can also contact their HCBS Specialist for technical assistance.

COMMENT: Do you anticipate some day programs to be approved based on the choice of individuals, or will it be program-wide? (Byers)

RESPONSE: Choice of settings and providers is a required element for all HCBS settings, and there should be evidence that all individuals receiving HCBS have the opportunity to make such choices. If issues are identified that indicate noncompliance, the provider will need to remediate the issue on a systemic basis, not just for an individual.

COMMENT: How will an assessment be conducted when day services are provided in a location attached to another building? How will the state assess a program where the member spends only part of the day program on site, but spends part of the day on outings with that program? (Blakestad)

COMMENT: What are the implications with pre-vocational and day habilitation? Will CMS release guidance more formally? (Grove)

RESPONSE: The guidance that has been released so far is centered on residential services. However, the regulation does apply to day services, and CMS is working on additional guidance. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

COMMENT: A lot happens before people get into our services, though, so, shouldn't TCM be documenting it? (Pingel)

COMMENT: Why not use the TCM Plan to show why people make the choices they do? (Stowe)

RESPONSE: The targeted case manager's service plan will very likely be one way of documenting individual choice. If documentation already exists that shows compliance, it may be presented in the assessment, even if it is from the case manager rather than the provider.

COMMENT: How much input will the state have on locations? Do we have to go to CMS for approval? (Salmen)

RESPONSE: The state will be assessing HCBS settings for compliance and requiring corrective action plans when necessary. During the assessment process, any settings that are found to

fall into the category of settings that are presumed non-HCBS, but which the state believes meet the regulation, must be submitted to CMS by the state for heightened scrutiny review. Settings that are presumed non-HCBS includes those that are located in a building that also provides inpatient institutional treatment; any setting on the grounds of or adjacent to a public institution; and settings that isolate participants from the broader community.

COMMENT: As you're looking at reviewing all these sites, DIA has licensure requirements already for assisted living. So, as part of your review if a place has a DIA license in good standing—can you deem them or grandfather them in as compliant to cut down the work for us and you. (Baddeloo)

COMMENT: We are under DIA and HCBS – and DIA is regulating more, so are we grandfathered based on what we have to do for them? (Vander Plaats)

RESPONSE: While the status of the facility's license is one indicator of compliance, the state has chosen to take a multifaceted approach to assessment in order to ensure that individuals receiving HCBS are afforded the full benefit intended by the regulation. As such, we will not be deeming any settings based on licensure or certification.

COMMENT: Since settings has already been in Iowa law, if the HCBS specialist has visited us and given us no red flags, does it mean we are compliant? (Dunshee)

RESPONSE: While many of the characteristics of HCBS have already been assessed through the current quality assurance process, there will be additional items that the department will be looking at based on the federal regulation and guidance published by CMS, so participation in the assessment process will still be necessary.

VI. Transition Plan: Remediation Strategies and Public Comment Period - Comments in this section are centered on the remediation strategies and public comment period portions of the draft transition plan.

COMMENT: As Iowa proceeds through the transition plan and develops rules specific to Iowa, it is important that we do not impose rules that are more stringent than the federal rules. (Kaestner)

COMMENT: Will rules and policy be written in Iowa to reflect the new federal regulations? (Althoff)

RESPONSE: Yes, Iowa will be adding these requirements to our administrative rules that govern HCBS services. Although the rules will be specific to Iowa, we expect that they will not be more stringent than the federal regulations. The rulemaking process takes a minimum of six months, and provides additional opportunities for public comment. We will also update our provider manuals when the rules take effect. Although rulemaking at the state level will take some time, the federal regulations promulgated by CMS are in effect now, and as such, the state and providers must start working now on assessment and remediation of HCBS settings within the state.

COMMENT: Action Step – Provider Assessment Findings – State will present each provider with the assessment of their organizational HCBS settings as determined through state review or provider self-assessment.

This actions step begin 7-1-14, however the assessment phase lists the modification of the self assessment starting 12-1-14 and ending 2-28-15. How can the state present providers

with an assessment that will not be developed until 6 to 8 months after the presentation.
(Schwanke)

RESPONSE: The assessment process includes several different activities which could yield results prior to completion of the self-assessment. The state will make providers aware of issues of noncompliance whenever such issues are discovered. In order to clarify our intent, the transition plan has been updated so that this item will read “State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.”

COMMENT: Action Step – Provider Individual Remediation –

This action step states that providers will self-disclose remediation plans with a proposed start date of 8-1-14. The self assessment that will be one of the tools used to identify sites/providers that will need to do a remediation plan proposed start date for development is 12-1-14. (Schwanke)

RESPONSE: The assessment process includes several different activities which could yield results prior to completion of the self-assessment. Whenever an issue of noncompliance is discovered, the provider will submit a corrective action plan. In order to clarify our intent, the transition plan has been updated so that this item will read “HCBS providers will submit a corrective action plans (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis.”

COMMENT: Action Steps – Compliance Tool, On Site Compliance Reviews, Provider Sanctions and Disenrollment’s, and Member Transition to HCB compliant setting proposed start dates do not make logical since. With the current proposed start dates, a provider could be disenrolled and members could be required to choose an alternative setting in the same month that the compliance tool is being developed and a full year before onsite compliance reviews are proposed to begin. (Schwanke)

RESPONSE: Iowa’s assessment and remediation strategy is based largely on our existing quality assurance process, which is an ongoing effort with different activities happening for different providers year-round. As such, the activities outlined in the remediation portion of the transition plan will be happening concurrently, with different settings and providers at different stages at any given time. In order to reflect this, many of the start dates begin in mid-2014 and many of the end dates extend through the proposed transition period in 2019. The description of many items has been updated in the revised version of the transition plan in order to clarify the process. As with our current quality assurance process, sanctions will only be imposed after a provider has failed a series of attempts to remediate the issue. Additionally, sanctions are typically given progressively beginning with a probation period, followed by more serious sanctions only if noncompliance continues.

COMMENT: Is there an appeal process for families that have family members that are in settings that no longer complies? (Mart)

RESPONSE: Remediation is being done through the Corrective Action Plan (CAP) process that is already in place for HCBS Quality Assurance activities, and the CAP process does include an appeal process. On an individual basis, the member always has appeal rights whenever services are changed or reduced.

COMMENT: Could there be requirements above and beyond the CMS requirements (state imposed requirements)? (Weimold)

RESPONSE: The language in the transition plan that says the state may “preset remediation requirements” is to assure that if a provider’s Corrective Action Plan (CAP) does not address an issue, or does not adequately address an issue, the state may prescribe the actions necessary to become compliant. Additionally there are other existing rules and regulations in the state that may still apply depending on the location, for example fire safety code, licensure laws, etc.

COMMENT: I do case management for the Elderly Waiver. I am happy that there is an extended transition period so that we don’t lose providers. In our 29 county area we only have one adult day care provider. Agency CDAC is also an issue because documentation requirements are extensive compared to reimbursement. We must tread lightly on how we support providers through this process or we will see an influx of people into the institutions; our role is to keep people in community not institutions. I am glad that there is a long term transition. This could really affect our providers in the rural areas. (Sindt)

RESPONSE: We are still waiting on additional guidance from CMS on day program services such as adult day care. The transition time allowed for any provider will take into account the scope and circumstances of the issues that require remediation; those circumstances could include factors like staff availability in rural areas and provider capacity in the area. The department will do what we can to support providers in making the transition, as our goal is to support people in the community rather than institutions and we also want to avoid any unintended consequences that could impede that goal.

COMMENT: Section 3 - Public Comment

PSA – Assessment Findings Report – the proposed end date of 7-31-15 which includes remedial strategies at aggregate and individual level are shared, however nine of the eleven remedial strategies have proposed end dates well after 7-31-15. (Schwanke)

RESPONSE: The intent was to share the results for the first year of onsite visits. However, it makes sense to continue this process throughout the transition period, and as such this item has been updated to read “State shares the findings of the onsite assessment annually by July 31.”

VII. Transition Plan: General Questions and Comments - Comments in this section are centered on the draft transition plan or the assessment and remediation process.

COMMENT: We would make two very general comments regarding the transition plan and the interface with Mental Health Redesign Legislation. First, regions are not included in the list of “players”. The Mental Health Redesign Legislation redesigned our community-based, person-centered system to provide: locally delivered services; a regionally managed system; and statewide standards. We feel it is critical to have the regions included in the transition process. Second, we agree it is essential that all individuals with disabilities have access to person-centered integrated services and have access to the greater community. We hope that DHS and Magellan are aware that the Integrated Health Home Intensive Care Coordination caseloads will

need to be reduced and rates adjusted to allow workers the time to implement person-centered planning. (Walters Crammond)

RESPONSE: The “players” column has been removed in the revised version of the transition plan. When necessary, stakeholders are noted in the description column for each item or in the explanatory narrative for each section of the plan. We agree that the mental health system regions are important stakeholders in this process and have added “Regional Mental Health and Disability Services Administrators” to the list of affected stakeholders in the public comment section of the plan. In regard to person-centered planning requirements, Iowa has emphasized person-centered planning for a long time and we don’t believe that extensive changes will be necessary to the planning being done by Integrated Health Home (IHH) Care Coordinators; however, we will be monitoring the situation as the IHH statewide roll-out occurs and will make adjustments if necessary.

COMMENT: The transition plan establishes the Department of Inspections and Appeals as a “player” to assist in identifying the qualities of an institution as well as location of congregate member living, however it does not address how DIA will ensure waiver and habilitation funded Residential Care Facility regulations are not contradictory. (Walters Crammond)

COMMENT: Regarding RCFs, where are you with DIA in conversations to resolve what they expect, with these rules? They require exit routes, fire drills, etc. (Wilson)

COMMENT: Last, but not least, this process opens an opportunity to make significant improvement in the ways in which services to persons with disabilities are provided. As you know, some providers – including Goodwill of the Great Plains – are currently required to comply with regulations through both the Department of Human Services and the Department of Inspections and Appeals. At times, regulations from these departments can conflict with each other and present providers with vague guidance.

The Department of Inspections and Appeals was originally identified for regulatory authority because of the higher level of care needed by many Adult Day Service participants. However, this meant that service locations were treated as healthcare facilities although no medical care was provided beyond feedings and medication administration. Regulating adult day services through DIA automatically forces service providers to fashion themselves after nursing homes and other institutionalized care facilities. Because community integration will now be the driving force in all HCBS settings, I strongly urge the department to consult with Governor Branstad and leaders from the General Assembly to assess the feasibility of organizing all HCBS regulations under the Department of Human Services. (VanderPlaats)

RESPONSE: The Department of Inspections and Appeals (DIA) does not regulate settings where HCBS is provided except for Residential Care Facilities (RCFs) and Assisted Living facilities. The two departments have discussed the regulation and will continue to work together to maximize consistency between each department’s administrative rules while assuring that DIA still meets federal requirements for survey and certification. Any rule changes made by either department will include the opportunity for public comment as required by state law.

COMMENT: As a provider that has been striving to provide community integration to our participants in HCBS programming for some time, this transition – while at times difficult and time-consuming – is absolutely essential to the continued efforts at achieving outcomes for those we serve. We believe that with increased community integration opportunities, those we serve will have more opportunities to meet their stated goals and continually strive to meet objectives that move them in the direction of independence.

The transition plan proposed by the Department appears to be well thought out and comprehensive in nature. As is often the case for providers, rules can often require a rapid transition to new regulations. We encourage the Department to make efforts at accommodating

reasonable timeframes for provider compliance with these new regulations. In the case of Goodwill of the Great Plains, some capital improvements may need to be made in order to allow for the best integration of our participants each day through different program outings. Such improvements require a significant resource investment, and may require some time to build resources. (VanderPlaats)

RESPONSE: The Iowa transition plan proposes utilizing the full five-year period allowed under the federal regulation in order to give providers ample time to make changes needed for compliance. We recognize that for some providers, this may include extensive policy and procedure changes or even physical infrastructure changes, and we have updated the remediation section of the transition plan to state “review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis.”

COMMENT: The plan for analyzing various program settings is very thorough, but several issues must be resolved before introducing this as the final rule. First, the term “facility” is not sufficiently defined in the documents provided by the Department. In traditional HCBS parlance, this term has been used to describe residential facilities. However, it is not clear if the proposed rule is referring to residential facilities or including rehabilitation facilities in the definition of the term “facility”. (VanderPlaats)

RESPONSE: To clarify this item, the terminology in the settings analysis has been updated to read “Day program settings located in a building that also provides other disability-specific services, or where provider offices are located.” However, CMS is working on additional guidance on day program settings, and this may undergo further revision based after that guidance is released.

COMMENT: Are the majority of the States doing similar transition Plans? (Laursen)

RESPONSE: All states will be required to submit transition plans when their waiver programs are due for renewal or within a maximum of one year from the effective date of the regulation. Iowa’s first waiver renewal was due during the same month the regulation became effective, so we are one of the first states to submit a transition plan, and are not aware of the approach being taken by other states. Our plan was submitted as a draft, and after considering comments from the public, we have made changes to the plan and are submitting a final version to CMS. Upon review, CMS may approve the plan or ask for additional changes.

COMMENT: Since there is no guidance on day services, will the settings rule be on hold for these settings? (Beavers)

RESPONSE: No, we will begin to assess day program settings based on the content of the federal regulation while we await further guidance from CMS on day program settings. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

COMMENT: Is the state plan totally being redone, or just components of it? (Dunshee)

RESPONSE: Iowa has recently submitted changes to the state plan for our 1915(i) Habilitation Services program, which included assurances related to the HCBS settings regulation. We

submitted changes to the ID Waiver in draft form in March 2014 in anticipation of the ID Waiver renewal date of June 30, 2014. CMS has granted Iowa an extension on the ID Waiver in order to allow time to incorporate changes due to public comment into our transition plan. When the ID renewal is submitted in its final form, Iowa will have 120 days to submit a statewide transition plan which will cover all HCBS programs within the state. Typically state plan amendments and waiver amendments will only make changes to certain components, while leaving other components in place; for example our waiver amendments will likely update the number of payment slots available, but will not change any service definitions.

COMMENT: Are the IPES and Provider survey results accessible to the public? It would be a good way to utilize provider information. (Hildring)

RESPONSE: Aggregate information from IPES results can be made available, but not individual responses, due to confidentiality. The Iowa Association of Community Providers (IACP) has worked with many RCF providers and is providing information to the department about issues that these providers face in meeting the settings regulations. An outside consultant is tentatively doing a provider survey for DHS regarding residential services will incorporate questions related to compliance with the setting regulations.

COMMENT: We do Day programming and ICF for people from 30 counties, in a campus setting. We have 50+ people with wheelchairs. We provide physical therapy, occupational therapy, speech therapy, etc. People get more choice because of our campus. Grandfathering will be important to us. (Grove)

RESPONSE: The comments and responses published with the federal regulation by CMS address the issue of grandfathering. The regulation does not specifically allow settings to be grandfathered in as being in compliance; however it does permit up to a five-year transition period to allow sufficient time to make changes necessary for compliance. Iowa's transition plan proposes use of the full five-year transition period.

COMMENT: The Prevention of Disabilities Policy Council was created by the Iowa General Assembly in 1991. The Council is responsible for facilitating policy development and coordinating state agency and public-private activities to prevent disability and improve the health and independence of those with disabilities.

The Council agrees that people with disabilities have a right to live, work and participate in the greater community and the Council appreciates the effort that has been made by the DHS to clearly identify a plan and time frame for changing policies in Iowa to implement the needed changes. The Council believes the proposed rule will help assure settings are integrated and providers fully support individuals receiving Medicaid HCBS to have a quality life in the community. The Council is encouraged that the rules include helping individuals find employment opportunities and work in competitive integrated settings, assistance to help them engage in community life, learn to manage their personal resources as able, and utilize services in the community to the same degree of access as individuals not receiving Medicaid HCBS. (Jones)

RESPONSE: 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: Collateral Damage - In the transition to assuring compliance we need to do what we can to minimize collateral damage. By collateral damage we mean we need to recognize

that there are people whose homes may not meet the new CMS criteria – but to them it is home. There are people who participated in a day service or heaven forbid a sheltered work shop for years and as with all of us – have part of their identity wrapped up in what they do. People should not be forced to change where they live or where they go to work because well meaning people who do not know them passed a rule. (Schwanke)

RESPONSE: The intent of both the regulation and Iowa’s transition plan is not to force anyone to change where they live or work, but rather to assure that individuals receiving HCBS are integrated in and have full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals who do not receive HCBS. It is our hope that no recipients of HCBS will need to relocate; however, it is possible that individuals may need to relocate if the department directs a provider to remediate an issue, and the provider decides to close a location rather than remediate. It is also possible that a provider could be disenrolled from providing HCBS services if they refuse to remediate an issue or are unable to gain compliance after multiple remediation attempts. Iowa’s transition plan addresses this possibility.

COMMENT: Throughout the Transition Plan references are made to technical assistance. What types of technical assistance will be available to providers who must accomplish large infrastructure changes as a result of these rules? (Strellner)

RESPONSE: Technical assistance on understanding the requirements, assessing specific HCBS locations, and remediation activities is available through your area HCBS Specialist from the HCBS Quality Oversight Unit. Technical assistance is available to all HCBS providers regardless of the size or scope of the changes needed.

COMMENT: Will there be a comprehensive state level plan developed with providers of larger facilities that includes enough time and funding to make such a transition? (Strellner)

RESPONSE: When the ID Waiver renewal is submitted in its final form, Iowa will have 120 days to submit a statewide transition plan which will cover all HCBS programs within the state. Iowa’s transition plan proposes use of the full five-year transition period. Funding for HCBS services is not changing at this time and will still be available for HCBS providers throughout the transition period. If additional funding beyond HCBS is needed, providers may need to explore other funding options.

VIII. Disability System Issues - Comments in this section are centered on issues that are related to the mental health, disability, and aging service system in Iowa. Many of these issues are related to system funding and workforce availability, and are beyond the scope of the HCBS settings transition; however we have attempted to address these comments to the extent possible.

COMMENT: Action Step – Provider Individual Remediation –

This action steps states that the state will allow reasonable timeframes for large infrastructure changes, however it does not address the fiscal impact of large infrastructure changes. Reducing number of people serve in a location or relocating services and/or starting new services is very expensive – what funds are available to assist with this transition? (Schwanke)

COMMENT: The new Rule that underlies this Plan offers an opportunity to substantially improve the lives of many people. The emphasis on helping them be as integrated as possible in their communities should result in many improvements in the lives of Iowa’s citizens with disabilities.

As we start this journey toward full compliance with the Rule, I have a number of comments and concerns to share with you. These are as follows;

I see that the State is requesting a 5 year time lime to be in full compliance with the Rule. That's good and we're definitely going to need that amount of time.

With the Mental Health Redesign that Counties have implemented over the past 2 years, I have watched with dismay as some people with disabilities involuntarily lose their homes and jobs (literally hundreds of people living in Residential Care Facilities or with paid work jobs in sheltered workshops). For many of those individuals, Redesign has been a very detrimental experience. I hope we learn from that experience and are very careful, as we implement this new Rule, to protect our service recipients from harm in the transition.

I predict that there'll be a need to transition from some existing settings to new, more integrated housing. In many cases, this will involve having to buy or build affordable housing. There are startup costs and capital costs associated with doing this. The State should lend help in both these areas and develop a method for doing so right away. The Iowa Finance Authority has a Fund that could be accessed for forgivable capital loans. Supporting and facilitating the Rule change to allow that should be a very high priority for IME.

Providing Day Habilitation and Prevocational services in integrated settings will drive up the cost of the services. There needs to be an acceptance of that reality from IME and a speedy, SIMPLE process to get funds to providers who are shifting from a more facility based model. Massive paperwork and lengthy, redundant justifications for why smaller groups or individual support takes more money are barriers to our mutually desired outcome of developing more integrated services.

The existing Supported Employment rate is a substantial barrier to helping individuals move from prevocational services to community based jobs. Fast tracking the development of a new, higher rate would be very helpful. Also, Vocational Rehabilitation will be receiving over \$2 million of new money to aid with Supported Employment. A real partnership between IME and Voc Rehab that utilizes a team approach to supporting people with disabilities getting and keeping jobs would be a real boost to helping Prevocational services be in compliance with this Rule.

Many services in Iowa are provided in geographic areas where it's a challenge to find qualified staff who can work for the wages offered by Providers. In some areas of the State, it's going to take a higher wage to recruit the additional staff required for a more integrated day service model and smaller residential settings. IME recognition of this fact and support for rate adjustments that allow the higher wages is a necessary precursor to the desired shift to more integrated settings.

One thing I like about this new Rule is its emphasis on outcomes as opposed to process and arbitrary limits on numbers of individuals living at a particular site or in a residential area. It's clear they're planning to avoid funding institutions. It's also clear they're avoiding a specific definition of how many people can live in a home or in geographic proximity to one another. It's not the intent of this Rule to prohibit congregate settings from being considered Home and Community Based Settings. That's good and I urge IME to adhere to this approach as well.

The above said, many providers, including Hope Haven, are looking for ways to reduce numbers of persons served in a geographic area and to shift to smaller residential sites. It would be a very good move for IME to offer incentives that help these transitions occur in Iowa.

Our service system is swiftly changing these days. There's an opportunity in this for people with disabilities to have a much improved lifestyle with doors opened that were previously closed to them. It will be a huge challenge to IME and to providers to make sure ALL persons with disabilities benefit from this transition. We at Hope Haven are quite willing to help with this transition and lend a hand to others as well. (Bartles)

COMMENT: Is money the driver? Because it's NOT going to be cheaper and maybe the feds are not aware that it's going to be a whole lot more expensive. I'm afraid we'll be back where we were 30 years ago with people sitting at home with nothing to do. (Grove)

COMMENT: The implication for rural area is transportation – it requires a lot more staff and vehicles especially if people are required to be in the community 90% of the time. (Patten)

COMMENT: Because individuals will have more one on one time, the staff cost associated with providing services will increase exponentially. These increased costs cannot be sustained over the long term, thus services will be cut and waiting lists will grow, which is not in the best interest of anyone. (Whitsell)

Contrary to Federal thinking, it's not always cheaper to provide services in the community than it is to pay for people receiving services in a work center. Providing 1:1 or 1:2 staff support to give individuals an integrated social or work experience is going to cost more than providing that same service in an activity or work activity center. (Whitsell)

COMMENT: Many individuals we serve have instances of aggressive behaviors. These situations only arise occasionally, but when they do, it is imperative that staff have sufficient assistance to handle the situation. Consequently, there will need to be special scheduling for these individuals to ensure that the supports are in place out in the community for the safety of the consumer, employee and other community members. This ultimately leads to significant increases in costs and likely is not sustainable. In the current environment, these supports are available because there is already several trained staff in the building that can assist when necessary, but can be helping with other groups when they are not needed, thus making the most efficient use of staff. Providing job and skill development in an integrated setting is difficult because employers are in such a competitive environment. Individuals with disabilities need special supports and many employers are simply unable to provide such an environment. This often times leads to frustrations for both the consumer and the potential employer and the end result is that the consumer is unable to learn new skills. In the current environment of a work center, these supports are able to be met and tailored to each person, thus resulting in successes. (Whitsell)

COMMENT: When you do more individualized services it takes more staff to do that. In January 2013 we transitioned people from RCF to HCBS and we added 8 full-time and 7 part-time positions to do so. Despite recruitment and retention efforts we continue to have a large number of vacancies. Direct support positions are physically and emotionally demanding and they work nontraditional hours. Carroll County has a low unemployment rate, so more that 60% of employees come from outside of Carroll; however, the six counties around Carroll have declining populations. I would request that providers have a reasonable timeline that supports service providers to develop strategies. Additional staff will be required as well as reimbursement rates that allow providers to hire quality staff. Give members receiving services the opportunity for input. The state can assist providers by providing best practices, and resources to assist us as we try to transition. (Mart)

COMMENT: The biggest challenges are adequate staffing and reimbursement rates. What do you suggest to help us address those issues? (Mart)

COMMENT: Day and Vocational Services

IACP eagerly awaits the CMS guidance on day and vocational services, as this change will have the largest impact on the service delivery system. As written, compliance with the current CMS final rule would require a significant increase in funding and commitment on behalf of the Iowa Legislature to support this change. It is inconceivable that a provider could offer services in a community based setting to individuals at the same level of funding that is currently utilized to offer congregate services, which does not meet the current funding need. (Chandler)

COMMENT: Many CPCs tell people this will be cheaper and so the Legislature believes that and does not appropriate more money to the cause. That is a disconnect. This is a more expensive way to provide services. It's MORE expensive for the State and the Federal government, it's only less expensive for the local government. (Bradke)

COMMENT: What happens when a member wants to live alone? It seems cost prohibitive and workforce prohibitive. I'm concerned about that. If someone identifies they want to live alone it may be a barrier to independent living. (Althoff)

COMMENT: We have a declining population, our starting wage is less \$8.93 you we have to pay staff to work nontraditional hours. There is a real disconnect with direct costs. We are struggling to find staff. We need consistent staff to provide services and supports. Our starting salary is \$1 less than other area providers. With the ACA you have to offer health insurance, we added a weekend bonus to get weekend staff, we are struggling to get staff coverage for five 24-hour sites and we are out of a community of 2,000! With HCBS rate rebasing we have to wait 3 years to get new rates because you can only submit a change for SCL rates when the member has a change in need, not when the provider has an increase in other costs. This is a barrier to us increasing wages, offering good benefits and hiring individuals. There is a real disconnect with actual costs. And you have to train the staff. And figure out how to keep that staff. It's real difficult. (Laursen)

RESPONSE: The department recognizes that Iowa's system for providing services for persons with disabilities and the aging population is complex and there are many challenges related to funding, both within Medicaid (including HCBS) and beyond Medicaid. We invite continued input from providers and the public as we work through the issues. Funding for HCBS services is not changing at this time and will still be available for HCBS providers throughout the transition period. That being said, the Department is currently working with community providers to explore different methods of reimbursement for Supported Community Living (SCL). The department is also part of a larger initiative involving providers and other state partners on restructuring rates for Supported Employment and Prevocational services. However, overall funding levels are not at the discretion of the Department; the budget is contingent upon what the legislature appropriates.

COMMENT: Many individuals with mental illness currently reside in licensed treatment oriented Residential Care Facilities in Iowa and do not receive state/federal funded HCBS services. Currently counties fund the costs of these services and for many individuals with mental illness this is a temporary and transitional living arrangement while their illness stabilizes and they work toward moving to a more independent setting. As the State of Iowa moves to the implementation of Regional service delivery July 1, 2014, will these Regions be allowed to continue to fund residential care facility services if they choose to do so, and the resident chooses to remain in this living situation? Since HCBS services are not being provided or paid for in these settings by the state can Regions choose to continue to fund residential care for those individuals who are not able to be fully integrated into the community due to the severity of their illness, or who choose to want to continue to live in this setting? (Strellner)

RESPONSE: The services mentioned in the comment are not HCBS and are not affected by the federal regulation or Iowa's transition plan.

COMMENT: Vera French operates Pine Knoll, a 60-bed Residential Care Facility for Persons with Mental Illness (RCF-PMI) that is currently filled to capacity with a waiting list. This would strongly suggest that there is a need for this level of care in Iowa. Pine Knoll would like to downsize, but have not been able to attain any type of financial support from the state of Iowa. We do not qualify for low-interest or forgivable loans through the Iowa Financing Authority, and have not been directed toward any other monies to pursue to assist us with this transition. Additionally, as RCF and RCF-PMI's were not included as core services for persons with disabilities, collectively this group of service providers are not certain of future continued sustainability of these programs as we are dependent upon the discretion of the regional board in which each facility is located. If Vera French Pine Knoll closes, this puts 60 high need persons with chronic mental illness in danger of losing their services with no appropriate placements to go into, potentially being sent away from their support network and the community they are familiar with. Despite winning the 2013 Governor's Award for Quality of

Care in Long-Term Facilities, we are afraid that we may not be able to serve this population much longer due to the new federal guidelines combined with a lack of state funding and support. As Senator Bolckham said during the 2014 Iowa legislative session, "The Mental Health and Developmental Disability Committee supports what it funds". RCF-PMI's have historically served some of the most chronically mentally ill residents in Iowa as they step down from inpatient hospital services or from Mental Health Institutes. We are requesting financial and technical support from the state to be able to continue serving this very vulnerable population as we come into compliance with both federal and Iowa guidelines. (Beenk)

RESPONSE: Providers may ask the legislature for appropriations without the advice or consent of the department. The department typically remains neutral on any such legislation.

COMMENT: In the efforts to move away from residential treatment settings, what options will be available for individuals whose support and treatment needs are greater than a community setting can provide? As these may be settings that do not qualify for HCBS, who will pay for these services? (Kaestner)

RESPONSE: It is a common misunderstanding that HCBS provides a lower level of care than institutional settings. Individuals with very intensive needs can be supported in the community with HCBS, or may be supported in institutional settings such as nursing facilities or ICF/ID facilities (with funding provided through other Medicaid authorities outside of HCBS). These institutional facilities are still available to eligible individuals in Iowa through the Medicaid state plan.

COMMENT: Thank you for the opportunity to comment on the draft Transition Plan intended to bring Iowa into full compliance with the CMS rule defining integrated settings for HCBS services. The use of public funds to support people with disabilities and mental illness in fully integrated service settings is central to the Olmstead vision of "Life in the Community for Everyone." The Taskforce fully supports the purposes and proposed approach of the draft plan published by DHS, including its extension to employment services which support opportunities to work in competitive and integrated settings. However, that support is tempered by awareness of the risks of unintended consequences as service systems and their funding streams are realigned.

When the Centers for Medicare and Medicaid Services promulgated a version of the proposed rule in the spring of 2012 and invited public comment, the Taskforce expressed general support, but stated that an extensive transition period would be needed. Providers who have in good faith developed service and housing models that are inconsistent with the rule on integrated settings need time, as does Iowa Medicaid Enterprise, for a careful, orderly transition that leaves no one without services. As facility-based services become less available, (and they will be, because more and more people will opt for services in integrated settings if that choice becomes a reality), we need to protect the choices and the quality of life for individuals whose needs are most difficult to meet. It is reassuring to see that CMS is allowing a five year transition period. The Taskforce will watch the transition process closely.

That being said, the Taskforce recognizes that the gap between the desired outcomes and present reality is huge, and a great deal has to be accomplished between now and 2019. The site assessment process for which timelines are presented in the draft transition plan will be an enormous and complex undertaking in and of itself, since its scope includes consideration not just of where people live and work but also how empowered they were to make meaningful choices about their situation. Measurement is bound to be inexact; what is to be hoped for is steady, observable progress in the expansion of real choices in every aspect of people's lives.

The Taskforce has several specific concerns and recommendations.

Capacity as a constraint on choices. There is considerable anecdotal evidence that Medicaid members today have sharply limited options not because providers and case

managers are insensitive to the importance of choice but simply due to a lack of community capacity. Providers cannot afford to maintain an array of “slots,” facility based employment is the only option in many rural areas, and affordable and accessible housing is in short supply. IME is already working with state partners on a number of important initiatives, such as the redesign of the employment service system to incentivize providers to shift focus to real jobs in integrated settings, and collaboration with the Iowa Finance Authority to increase access to affordable housing in the community. The Taskforce has consistently supported these efforts and will continue to do so.

A particular concern of the Taskforce has been disability-specific housing projects with high concentrations of individuals receiving HCBS services. IME was already working to ensure more integrated settings, and we support those efforts, even though CMS seems to have backed away from the more restrictive approach taken in 2012. We strongly support efforts to ensure compliance with the rule’s prohibition of HCBS services on or adjacent to campus settings of institutional providers. Promoting more integrated settings in these instances will, again, require access to affordable, accessible housing in the community.

Another major concern related to system capacity is the difficulty in attracting and retaining competent direct support staff. Providers, who already face challenges in this area, are concerned that the new rule’s emphasis on individualized supports will require higher staffing levels. Offering differential reimbursement rates based on staff competencies may provide some help in recruitment and retention.

Awareness, attitude, and education. Money Follows the Person transition specialists cite the importance of natural supports (family, friends and community) in overcoming obstacles faced by residents of ICFs/MR who want to return to community. Not every Medicaid member residing, or at risk of residing, in an institution will have the good fortune of a watchful case manager interested in securing their independence in the community, family members willing to build accessible homes for them, and providers willing to take on people with complex needs, but any such success stories need to be told widely, in person, online and in printed materials. The Taskforce suggests that opportunities be sought at conferences, staff trainings and parent meetings, to help all stakeholders understand the significance of the new rule for disability rights under Olmstead, and their responsibilities to protect those rights. Education on the rule might be incorporated as a training module in the College of Direct Support, with workers specifically encouraged to describe their efforts to implement what they have learned in their online portfolios.

Financial incentives. The Taskforce supports IME’s on-going efforts to provide financial incentives to providers to shift from institutionally-based services to HCBS.

Compliance. The Taskforce recognizes the good faith of many providers who have committed to working with DHS to achieve compliance with the new rule. In the end, the mission of the Taskforce is to monitor Iowa’s progress in achieving disability rights under Olmstead. Regardless of whether a failure by providers to comply is due to financial concerns, inability to recognize the real potential of people with disabilities and mental illness to live successfully in the community, or the belief that somehow, in the end, the weight of the status quo can stall momentum towards positive change, that failure is unacceptable and DHS may have to take appropriate action. The Taskforce recognizes that the five year transition plan is an attempt to build the necessary partnerships to achieve the purposes of the rule, in a careful process which leaves no consumer behind. (Lauer)

RESPONSE: The department appreciates the support of the Taskforce in making this important transition. We also share the concerns about system capacity and are proposing to use the full five-year transition timeline allowed under the regulation in order to allow sufficient time to overcome these challenges. We will continue to work to ensure that all recipients of HCBS throughout Iowa will benefit from the opportunity to live and thrive in truly integrated community settings.

COMMENT: Person Centered Planning

Person Centered Planning has been an industry standard for many years but the final rule specifies a process that reflects individual preferences and goals while allowing individuals to direct the process. IACP is supportive of creating both process and practice that will make this a reality.

Currently, the case manager assigned to the individual, directs the planning processes. Decisions are made about services that will be authorized not based upon individual preferences and goals but rather upon arbitrary decisions made by case managers and criteria being subjectively applied. Individuals in some cases are working on goals or living in situations not based upon choice but rather based upon what is allowable in the eyes of one individual (case manager), who in some cases may have a significant conflict of interest.

CMS specifically states that the person-centered planning process, “Offers informed choices to the individual regarding services and supports they receive and from whom.” Current enrollment regulations only allow entities to provide case management services that are designated by one of the MH/DS Regions in Iowa. This significantly impacts the ability of an individual to choose case management services based upon their preference and needs. Allowing case management entities to enroll in the same method as other Medicaid providers allows individuals the ability to choose from many different providers as to the entity that may best suit their needs.

Recommendations: The CMS final rule provides Iowa an opportunity to move away from a service delivery environment focused on compliance and shift to a model that focuses on outcome and individual member experience. IME can take a leadership role in this process by:

1. Creating an oversight environment that focuses not solely on compliance but rather on real world outcomes for Medicaid members.
2. Ensuring providers have the necessary resources and data based upon member outcomes to make decisions that will positively impact the member experience.
3. Work collaboratively to create policies that support member outcomes as the driving force in service delivery decisions.
4. Implement a true conflict free case management system.
5. Develop clear criteria for the implementation of person centered planning.
6. Offer consistent training for people at all levels of the system, including family members and the Medicaid member, on person centered planning. (Chandler)

RESPONSE: Although person centered planning is part of the federal regulation, the regulation does not allow a transition period for implementing the person-centered planning process, and as such it is not addressed in Iowa’s transition plan. Iowa has emphasized person-centered planning for quite some time. Current Iowa Administrative Code for Targeted Case Management (TCM) includes the requirement that the case manager will ensure the active participation of the member in the development of the service plan including the choice of goals and providers. In regard to concerns about limitations on choice of TCM providers, Medicaid members are able to choose from any enrolled, qualified provider; they are not limited to the provider designated by their MH/DS region. Iowa is currently in the process of implementing conflict-free case management through the Balancing Incentive Payment (BIP) grant.

COMMENT: It is clear that Iowa has a strong history of initiating structural and systematic changes to promote the utilization of community-based services and supports for consumers who are elderly or are adults with physical disabilities. While we appreciate that the exercise currently before you is to assess the services and settings that are currently available in Iowa, we would like to take this opportunity to let you know about an innovative and comprehensive model of care that we call Structured Family Caregiving. This model, utilized in multiple states, supports elders and consumers with disabilities to live independently in their homes, a “setting”

that fully meets the regulatory intent and compliance expectations of the HCBS Final Rule published by the Department of Health and Human Services. Making this service available in Iowa would help to continue Iowa's efforts to support consumers' independence by offering a person-centered model of care in homes chosen by those consumers.

Caregiver Homes delivers Structured Family Caregiving to more than 2,100 consumers across five states. We support adults of all ages who have significant need for assistance with personal care, such as bathing, ambulating, and toileting, and complex behavioral and medical conditions. We are supporting individuals – who would otherwise need services in more restrictive and expensive settings – to receive needed supports at home.

Through our experience, we have come to identify program features that enable Structured Family Caregiving to successfully support consumers with complex needs in the community.

- Ability for family members and non-family members to serve as paid caregivers – a passionate, committed, and high quality workforce;
- Matches between consumers and caregivers that are responsive to the high level of personal care and care coordination needs of consumers who choose Structured Family Caregiving;
- Consumer or caregiver's home a Setting – this is critical for meaningful adoption of the service;
- Provider agency oversight and support of caregivers – this is key to long-lasting, high quality services and promotes access by streamlining processes for credentialing caregivers and qualifying home settings;
- Daily payment rates that allow for modest caregiver financial stipends and sufficient provider agency staff support (e.g. home visits);
- Access to complimentary home and community based services, to enable appropriate respite for committed, full-time caregivers, and fill access to the greater community for consumers

Caregiver Homes believes Structured Family Caregiving would be a comprehensive and cost-effective option for Iowans who need extensive supports to live in the community. We would appreciate the opportunity to work with you as you implement your Transition Plan to identify how best to make this model work in Iowa, including assisting with the development of necessary Waiver language to authorize Structured Family Caregiving, and answering questions about how this service operates in other states. (Crosbie)

RESPONSE: Iowa does not plan to add any new services to our HCBS programs at this time. However, Structured Family Caregiving may currently be allowable as a service delivery model under the ID and BI waivers as Supported Community Living (SCL). The Department is exploring alternative supported living service delivery options that would meet the HCBS settings requirements.

COMMENT: There is also considerable concern that the department will interpret CMS directives to include a 1:1 ratio of staff to participant in all HCBS programming. Requiring a 1:1 ratio would be detrimental to the dollars allocated to waiver services, the participants and providers alike. First, a 1:1 ratio would prove to be far more expensive than a 1:5 – 1:10 ratio of staff to participants. Providers cannot provide that level of staffing without significantly increasing the rates charged to the Medicaid for the services. It is not the intent of CMS to increase the cost of services provided under Home and Community Based Services, but rather to increase the effectiveness of such services. With a 1:1 ratio, Goodwill of the Great Plains fears participants will no longer have the opportunity to enjoy integration in the community with their peers, but instead will be forced to integrate with a staff member. (VanderPlaats)

RESPONSE: Iowa is not requiring a 1:1 staff-to-member ratio in any of our HCBS programs. Staffing levels will continue to be based on each member's assessed need for services and supports.

COMMENT: How do you see services looking differently? (Mart)

RESPONSE: The majority of HCBS settings in Iowa are already on the right track for compliance. Iowa has promoted the concepts of community integration and member choice for many years. We would expect that individuals will receive services that give them the opportunity to participate in their communities to the same extent as persons not receiving Medicaid HCBS. It is likely that more services will be provided in smaller, community integrated sites.

COMMENT: How will other federal entity decisions (e.g., DOJ) impact the transition or are there high priority interests that will influence the transition of some settings? (Petersen)

RESPONSE: The department is aware of the recent DOJ findings from other states pertaining to the Americans with Disabilities Act and the Olmstead decision. It is the intent of the department to fully comply with the intent of the ADA and Olmstead decision. We believe that Iowa's proposed transition plan is in line with these findings and plan to proceed with the plan, but do have the option to make changes to the transition plan if needed. Any substantial changes to the transition plan will have another public comment period.

COMMENT: It's not HCBS funding but Woodward and Glenwood – the argument is really hard to convey, but caring for people in those institutions is really expensive. If we moved them to the community we'd have a lot more money in the system. (Petersen)

RESPONSE: The state-run resource centers have successfully served many individuals who have had difficulties being served in other settings. Nonetheless, the resource centers do actively make efforts to transition residents to community settings, often utilizing the Money Follows the Person program to do so.

COMMENT: Is there any plan to change or replace TCM? (Dank)

RESPONSE: The role of Targeted Case Management providers should not change due to the HCBS Settings transition. There may be some changes in processes for TCM due to the new federal regulations on person-centered planning, and the core standardized assessments that are being implemented through the Balancing Incentive Payments grant. For members with chronic mental illness, care coordination will be done by an Integrated Health Home rather than by TCM, but there are no plans to replace TCM for other populations at this time.

COMMENT: How involved are the school systems to prepare students for real jobs? Right now a lot is being done for transition aged students but where is the Department of Education in all this? (Boeve)

RESPONSE: The Department of Education and the Iowa Vocational Rehabilitation Services Departments are currently involved in the broader conversations on what needs to be done in schools for transition age youth. One of the difficulties has been that results have differed between school districts. There are current efforts to identify best practices and evidence based interventions that can be done more uniformly throughout the state.

COMMENT: We recognize change is needed, but by the time we get legislation to change it's no longer what we need. I still have a lot of people who are court ordered to 24-hour supervision because of their behavior but I have Magellan telling me they'll be out on their own in 6 months! Need to address the disconnect. (Marxen)

RESPONSE: This issue is unrelated to the HCBS settings regulation and Iowa's transition plan. Often courts are unaware of Medicaid eligibility and funding requirements when such court orders are made. We suggest utilizing the appointed mental health advocate in your county to assist with these situations.

COMMENT: Please define person-centered planning. Is this the same as an ICP? (Blakestad)

RESPONSE: Person centered planning is the use of the interdisciplinary team directed by the member. The member should be leading and directing the team; taking an active role in ICP development. This is often reflected by members and advocates with the phrase "nothing about me without me." Although Iowa has emphasized person centered planning for some time, members have at times been a bystander to plan development. The expectation is that the member will actively participate to the best of their abilities.

COMMENT: Has any consideration been given to reducing the amount of paperwork required of assisted living facilities? (Roemen)

RESPONSE: This is a separate issue that is unrelated to the HCBS settings transition. Assisted living facilities must adhere to the requirements from all agencies that have oversight for that facility. The documentation requirement for the Department of Inspections and Appeals is very different from the documentation required by Iowa Medicaid. The documentation done for HCBS services is to substantiate the service and payment from state and federal funding. All providers who receive HCBS funding are required to maintain detailed documentation; this is not unique to assisted living. If the provider documentation is not sufficient to substantiate billed charges, then the provider is at risk of monetary recoupment.

COMMENT: I know there are many changes that are coming about as a result of the Affordable Care Act, and many of the changes are good and have been needed. But cutting funding for any of the above reasons to cover the costs for uninsured or underinsured Americans does not make any sense. It is "robbing Peter to pay Paul." Handicapped or Intellectually Disabled adults are already discriminated against and have very limited options for a full life. If more dollars are needed for the Government to provide these services, make changes to Medicaid and Medicare programs that help support single women with multiple children. Limit what services they can receive and for how long by making them engage in educational programs to improve their earning potential. Make them give back to the system (when they are in better financial circumstances) to support services for the people who come after them. I know I would rather have my tax dollars go toward supporting people who cannot fend for themselves rather than giving benefits to able-bodied or able-minded individuals who at least have the capacity to help themselves. Please find other ways to balance the budget, rather than taking away services from those who can least afford to lose them! (Bustad)

RESPONSE: The HCBS settings regulation and Iowa's transition plan do not cut funding for any HCBS services or supports.