Iowa HCBS Settings Transition Plan
Public Comments
November 2014

Process:
Public comment on the settings transition plan was taken from October 15, 2014 through November 30, 2014. The public was invited to submit comments through a dedicated email address (HCBSsettings@dhs.state.ia.us) and stakeholder forums were held via webinar on November 18, 2014; November 19, 2014; and November 24, 2014.

The statewide settings transition plan, along with the settings transition plans for the Brain Injury Waiver, the Elderly Waiver, the Children's Mental Health Waiver, the Health and Disability Waiver, the Physical Disability Waiver, and the AIDS/HIV Waiver, were posted to the DHS/IME website on October 14, 2014. This included the transition plans, the settings analysis, the Iowa Exploratory Questions for Assessment of HCBS Settings guidance document, and the Iowa Settings with the Potential Effect of Isolating Individuals guidance document. The website posting included instructions on how to submit comments.

In addition to the announcement on the website, the department directly contacted provider organizations and consumer advocacy organizations to inform them of the public comment period and stakeholder forums. Organizations contacted include: Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, and ASK Resource Center. The department also invited comments through the release of Informational Letter No. 1436 to all HCBS waiver providers, case managers and DHS social workers on October 23, 2104.

Summary of Comments:
The webinar stakeholder forums were attended by 147 people; questions and comments were submitted by 18 individuals. An additional 6 people submitted comments via email.

The vast majority of questions and comments received centered on the requirements in the federal regulations. Most questions and comments did not specifically address the Iowa transition plan per se, but rather were seeking clarification or interpretation of the federal regulation and how it may apply to specific situations of interest to the commenters. Only one comment directly asked for a change to the Iowa transition plan; this was related to Iowa's interpretation that when a provider is present on a 24-hour basis, the setting is operated by the provider and as such, the location would be considered a provider controlled setting. The state responded that settings where a service provider is present on a 24-hour basis will be subject to the additional requirements for provider-owned or controlled settings, but clarified that providers of 24-

hour services are not automatically considered out of compliance. Compliance will be determined by looking at the experience of the member in the setting.

Full Comments and Responses:

Persons submitting comments:
Denise Beenk, Vera French Pine Knoll (forum)
Diane Brecht, Abbe, Inc. (forum)
Calvin Carver, Cherokee County Work Services (forum)
Shelly Chandler, Iowa Association of Community Providers (email)
Joseph Claibourn, xIst LLC (forum)
Laura Coco, AHMS (forum)
Deanna Heimerdinger, Opportunity Homes, Inc. (forum)
Cindy Hess, Hillcrest Family Services (forum)
Harry Jacoby, Access, Inc. (email)
Brandi Jensen, Brain Injury Alliance of Iowa (forum)
Terry Johnson, Genesis Development (forum)
Elizabeth Jones (email)
June Klein, Brain Injury Alliance of Iowa (form)
Geoffrey Lauer, Brain Injury Alliance of Iowa (forum)
Cindy Lawler, New Hope Village (forum)
Teresa Naughton, LifeWorks Community Services (forum)
Bill Nutty, LeadingAge Iowa (forum)
Jill Olson, Des Moines, County Case Management (email)
Joan Osborn, Link Associates Case Management (forum)
Mary Lynn ReVoir, National Disability Institute (forum)
Simone Schmitt, Spring Harbor Residential Services (forum)
Deborah VanderGaast, Tipton Adaptive Daycare, LLC (email)
Robert Wharram, Mental Health/Disability Services East Central Region (forum)
Mary Ann White, WCDC, Inc. (email)

COMMENT: If we complete our self-assessment and identify that a setting is out of compliance, are you saying that we have until March 17, 2019 to come into compliance? In other words, we can use the full 5 years to come into compliance? (Brecht)

RESPONSE: The remediation section of the Iowa transition plans state that the review of Corrective Action Plans by the department will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. As such, the timeframe allowed to come into compliance will depend on the scope of the issue for that particular location, and may be less than the full 5 years. The deadline of March 17, 2019 is when all settings in the state must be compliant.

COMMENT: Are 58 bed RCF's able to provide Habilitative services to individuals living in the facility? (Schmitt)

COMMENT: Some of the county workers are communicating that RCFs are going to be required to downsize to 15 beds and soon after required to go down to 4 beds. Is this true, and if so, what is the timeframe for it to occur? (Coco)
COMMENT: There are a large number of RCF's over 16 beds that serve over 51% of persons with chronic mental illness. What assistance does the state plan to provide to downsize these facilities, as beds are currently scarce and downsizing is costly; most providers do not have the funds to achieve this. (Beenk)
RESPONSE: Neither the federal settings regulation, nor the Iowa transition plan sets a limitation on the number of beds, or requires providers to downsize, although some may choose to do so because larger settings may have increased risk of having institutional qualities. The Iowa Department of Human Services (DHS) does not have funding available to assist in downsizing. Providers may be able to qualify for low-interest loans from the Iowa Finance Authority. Please note that there are other federal regulations and state laws which place limits the number of beds allowed in some locations.

COMMENT: Are the requirements the same for settings that are not provider owned or controlled? As far as the new setting rules, do we need to show the same info in the plan as far as having privacy and their own room, etc? (Heimerdinger)
RESPONSE: The federal regulation sets requirements for all HCBS settings, and includes additional requirements for HCBS settings that are provider-owned or controlled. All HCBS settings must meet the following requirements:

- The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community like individuals without disabilities;
- The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
- An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- Individual choice regarding services and supports, and who provides them, is facilitated.

Additionally, provider-owned or controlled settings must meet the following requirements:

- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity.
- Each individual has privacy in their sleeping or living unit.
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

- Individuals sharing units have a choice of roommates in that setting.
- 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.

COMMENT: You said that if a person leases who is not a provider then the setting rules do not apply - do you mean as long as it is not a 24 hour site which is provider controlled? Sometimes the lease is with a complex but the provider controls the site 24 hours a day. (Osborn)
RESPONSE: Part of the federal regulation applies only to provider-owned or controlled residential settings, as noted in the response above. In determining what constitutes a provider-owned or controlled setting, the department has looked to the guidance published with the federal regulation. This guidance states “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”. The department has interpreted this to mean that when a provider is present on a 24-hour basis, the setting is operated by the provider and would be considered a provider controlled setting. As such, the additional requirements would apply to these settings.

COMMENT: In the commentary written on the HCBS 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.” 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.” Recent changes to the HCBS Provider Self Assessment have required providers to label 24 hour service delivery settings as “provider controlled” and asked them to develop plans to come into compliance.

ANCOR, a national association representing service providers across the country, who has been in direct contact with CMS regarding interpretation of the final rule stated: "Iowa: If residential services are provided 24/7, that looks like provider controlled and won't meet the criteria. That sounds like a state interpretation and NOT something CMS is saying."

IACP objects to this restrictive definition when the Federal rules clearly state that it will be the “experience of the member” that defines the quality of the setting. We do not support IME’s decision to take this narrow view of the settings definition and request that this requirement be withdrawn.

1. How will the member’s experience be measured to determine whether a setting is community based?
2. How often will this be measured and who will be responsible for measuring it?
3. Will aggregated data be released on member’s experience? (Chandler)

RESPONSE: The federal regulation sets requirements for all HCBS settings, and includes additional requirements for HCBS settings that are provider-owned or controlled. All HCBS settings must meet the following requirements:

- The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community like individuals without disabilities;
- The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
- An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- Individual choice regarding services and supports, and who provides them, is facilitated.

Additionally, provider-owned or controlled settings must meet the following requirements:

- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity.
- Each individual has privacy in their sleeping or living unit.
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- 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.

In implementing these regulations, the department has looked to the guidance published with the federal regulation in order to define what constitutes a provider-owned or controlled setting. This guidance states "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". The department has interpreted this to mean that when a provider is present on a 24-hour basis, the setting is operated by the provider and as such, the location would be considered a provider controlled setting.

This means that the additional requirements noted above apply to these settings; however this does not mean that providers of 24-hour services are automatically

considered out of compliance. Compliance will be determined by looking at the experience of the member in the setting.

The intent of the federal regulation in setting out additional requirements for provider-owned or controlled settings is to ensure that individuals in those settings are afforded protections to ensure that their rights are not unduly restricted and that they have choice and control over their own lives to the same extent as others living in the community. Individuals who require 24 hour supports should not have to give up the expectation to have protection from eviction, to expect privacy in their own home, to choose with whom they reside, and to have control over their daily activities.

In response to the specific questions about how will the member's experience be measured, how often it will be measured and who will be responsible for measuring it, and whether aggregated data be released; the transition plans outline in detail the ways in which assessment will be conducted, who will participate, the timeframes, and the release of aggregated data. The transition plans are all available on the DHS website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans.

COMMENT: What if a provider's management staff has family who owns the home individuals receiving services live in? Would that be considered provider owned or controlled? (Claiborn)
RESPONSE: It would depend on the relationship of the property owner to the provider's management staff. The department would have to look at any such situation on a case-by-case basis to make a determination. Even if the setting was not determined to be provider-controlled, there could be a conflict of interest for the provider.

COMMENT: "Live with" does that mean in the same house or the same room? (Johnson)
RESPONSE: In regard to the choice of roommates in provider-owned or controlled housing, this refers to areas where physical space would be shared between two or more persons receiving HCBS. For example, two persons sharing sleeping quarters must be able to choose their roommates. Likewise, two persons who have their own bedrooms but have other shared areas such as bathrooms, kitchens, or living rooms must also be able to choose their roommates. In the example of individuals who have separate apartments within the same building, without sharing any common living area, those individuals would not have a choice in who lives in the other apartments.

COMMENT: What happens with facilities that take committed individuals? Will HCBS be able to be provided? (Hess)
RESPONSE: Any time an individual receiving HCBS has an outpatient commitment, any rights restrictions imposed by the court should be addressed by the interdisciplinary

team through the person-centered planning process; this includes any court ordered restrictions that are contrary to the settings regulation. The person-centered planning process should still aim to use the least intrusive method, and to set time limits for review, and to measure the effectiveness of the restriction. The plan should include the option to petition the court for a change in the court order when it is appropriate for the restriction to be reduced or removed.

COMMENT: If advocates find that providers are not in compliance with these guidelines, what is the first step? (Jensen)
RESPONSE: If the advocate is involved as a member of an individual's interdisciplinary team, it would be appropriate to address the issues with the provider through the person-centered planning process. Advocates can also contact the HCBS Specialist for the area with any concerns about compliance with the settings regulations. Current contact information for the HCBS Specialists is available at: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts

---

COMMENT: Can you discuss how to apply a rights restriction/modification when it affects roommates? For example, if food is restricted for one person but not necessary for others, they may end up being restricted by the nature of being roommates.
RESPONSE: These situations will need to be addressed through the person-centered planning process with each individual's interdisciplinary team, in order to find solutions that can meet the needs of both members. For example with food restrictions, it may be possible to lock cabinets but provide the member without restrictions with their own key so that they may still access their food at any time.

COMMENT: What qualifies as a public institution? A hospital? Library? (Lauer)
COMMENT: What's the definition of "public institution"? (Nutty)
COMMENT: Is a school a "Public Institution", and cause issues with the HCBS settings rule? (Naughton)
RESPONSE: This was addressed by CMS in the responses to public comments received on the federal regulation. Their response was as follows: "The term public institution is already defined in Medicaid regulations for purposes of determining the availability of Federal Financial Participation (FFP). Section 435.1010, specifies that the term public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Medical institutions, intermediate care facilities, child care institutions and publicly operated community residences are not included in the definition, nor does the term apply to universities, public libraries or other similar settings. We will apply this existing definition in implementing the provisions of this final rule."

COMMENT: Will there be any further clarification coming as to how vocational/day service settings will be viewed? (Lawler)

RESPONSE: CMS released further a set of exploratory questions on non-residential settings on December 15, 2014. The intent of the guidance is to "serve as suggestions to assist states and stakeholders in understanding what indicators might reflect the presence or absence of each quality in a setting. These questions are not designed to be a score sheet and not all questions relate to every HCBS or every individual served." The guidance is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

---

COMMENT: Could you please address if Prevocational Training can be funded by HCBS if it takes place in a Sheltered Workshop? Please address Day Habilitation settings. (Naughton)
COMMENT: What are the plans to assist those who CMS are taking the right to work away from the clients who cannot find work in the community? (Carver)
RESPONSE: The federal settings regulation does not take away the ability for states to provide HCBS services other than supported employment, such as prevocational services. This regulation does not prohibit prevocational services from being provided in a sheltered workshop; however, other existing federal regulations do state that prevocational services are not to be provided in sheltered workshops. Additionally, under federal definitions, prevocational services are meant to be transitional in nature and must be time-limited.

With any HCBS provided in a setting that congregates a large number of people with disabilities in one location, there is increased risk that the location may have some of the qualities of an institution. We expect that the settings across the state will fall on a continuum from those that need little or no remediation to others that may need extensive remediation. All such locations where HCBS is provided will be assessed for compliance with the regulations. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community. We suggest that providers of these services utilize the exploratory questions guidance for non-residential settings that was released by CMS on December 15, 2014. The guidance is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

---

COMMENT: All of our services in our Adult Day Habilitation program are for persons receiving HCBS services. In our program services we giving the members there choices of what they want to do and if they want to participate in the activities. Our program also includes taking the members out in the community on outings 2 to 3 times per week.

Our setting falls under being a facility that houses Adult Habilitation and Prevocational services along with our office. Do we need to have our Adult Day Habilitation members in the community every day? Can our setting fit into an approved facility to provide HCBS services? (White)

COMMENT: I have worked in this field for over 40 years and continue to serve as Executive Director for a smaller provider in a rural area in Iowa. I have always been a strong advocate for persons with disabilities to access competitive community employment through Job Placement and Supported Employment. I was placing individuals in jobs and job coaching them as early as 1973 and through the years continued to advocate for adequate funding to carry out placement and follow along. In the 1980's placement was spurred on by grants for placement and follow along services, however, the follow along dollars were reduced and typically were limited to 2-4 hours a month which was ridiculous. Most smaller providers were forced out of providing placement and follow along services. Now that this is again a national movement and effort, I would hope that the key element of enough hours and reimbursement for follow along services to maintain competitive employment will be the case.

As far as the HCBS new rules, I have a couple of deep concerns. One being that administrative staff should not be in the same building where services are provided. In our small facility this would mean the majority of administrative and management staff would need to relocate in our small community. The cost would include rent for offices, another secretary, another copy machine, another fax machine, utilities, phones, and so on. If every provider did this the cost to Medicaid would markedly increase in Iowa and also in every state. I would expect that Medicaid dollars would shrink and there would be problems. I would then think that some individuals with disabilities would be placed on waiting lists or funding would be discontinued. Even more important, the administrative staff and management staff have long been vital resources to persons served. Every day it seems that one or more of the staff are needed as resource personnel. Needs include a wide range of areas such as actually filling in on the floor for staff absences, consumers (members) who need to talk with their Payee (administrative staff person), questions from persons served, questions from direct support staff, problems with the building (toilets, etc.) addressed by our Director of Development, and so on. Also, I gain the majority of input for the needs of persons served from interactions on a daily basis with the persons served. In summary, I strongly believe that removing key resource people to another part of town will not only cost a great deal of money, but it will remove key staff and cause a decrease in effectiveness and efficiency. I am all for community integration which is why I started a group home in 1973 and another one in 1974 to get persons with disabilities out of institutions. I lived with them as a "houseparent" and received $200 a month room and board. I learned more from these people with disabilities than I did throughout my studies that led to a masters degree in special education.

I hope that the actual desires of persons with disabilities will be the focus and not what would "appear" to be the best setting for them. Increased costs to Medicaid to relocate offices will not help anyone in my opinion. The majority of current services in Iowa are very good and better than in most of the states I have visited programs in. There have been many studies about the best learning environment and the bottom line

was that the teacher was the most important factor not the building. If anything we need to raise the wages of direct support professionals and worry less about which building is used for what. (Jacoby)
RESPONSE: Day program settings that are held in the same building as provider offices are not automatically excluded as an HCBS setting. However, such locations may have increased risk that the setting may have some of the qualities of an institution. In any such location, the requirements of the HCBS settings regulation must still be met, such as self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted. We suggest that providers of these services utilize the exploratory questions guidance for non-residential settings that was released by CMS on December 15, 2014. The guidance is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

---

COMMENT: Did you say that comments for the ID waiver has already occurred? Can comments still be given during today's forum? Can comments for the transition plan and for the ID and BI Waiver renewal be submitted via the web? (ReVoir)
RESPONSE: The public comment period for the ID Waiver settings transition plan was held in May 2014. The public comment period on the ID Waiver renewal application is taking place from November 1 – November 30, 2014. Public comments on the settings transition plans for the remaining Waiver programs and the statewide settings transition plan are also being held from November 1 – November 30, 2014. Comments for all of these may be submitted to the dedicated email address: HCBSsettings@dhs.state.ia.us.

COMMENT: I have heard that a client should tell if he/she is feeling isolated, what if the client is nonverbal? (Wharram)
RESPONSE: This should be communicated in whatever is the usual mode of communication for the individual.

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

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

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

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

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

COMMENT: Just input on how the HCBS tenants are being assessed.
I really like the way the assessments are being done. There are decent person that really care and are honest working with the special needs persons.
That being said there are a lot of persons just working because it is a pay check. They do not allow the time to work with their clients and do almost everything themselves instead of taking the time and really teaching the persons to be more independent. Ex: You're told a consumer can stay up to 2 hrs by him/herself. Ok but this person cannot use the stove and will trash a variety of things when left alone. So is this person not going to try to use the stove or is this person not going to trash something (remember it can be anything) if left for 2 hrs. That's a long time. These are the people that are working in the HCBS settings saying this person can stay alone even though they cannot use a stove and is destructive towards property on a regular basis. Looking at each person separate and how and what services are needed will work. It should have been this way but we all learn along the way. If you think about it not everybody brings home the same amount of money on their paycheck same difference, each person has their own lifestyle and should be paid off of that lifestyle when assessed. Yea, it might be more time consuming and a longer process to look at each person but in the long run it will cut out dishonest persons that have and will try again to take money from the

people there helping. It's time other organizations look into doing the same procedure and not base everything on a curve and come up with a assessment that will be similar because it you think about it persons living on their own and needing assistance is not much different than persons living in a HCBS setting = these people just have someone telling them how to spend their money. Not a bad idea for a lot of people maybe more of the assistance would be directed towards the children and their needs and not community intake the parents use it for. Keep up the great work in how you dispense money so it can be tracked better. Now we need more input given on not all special needs persons can go out in the community and work there will always be a need to have some type of training facility available to continue with persons who cannot go out and work to maintain their dignity. (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: In the past, I have not commented on issues thinking it won't matter. I feel I need to now. I am appalled at the changes the government/Medicare/Medicaid thinks is better.

I disagree with the plan to not allow group homes and campus type settings. My experience working with ID waiver for 18 years has shown me that safety within a campus type setting is greater than in a site house. Campus settings have worked great in Burlington, Iowa, with Hope Haven, a major provider. Consumers can be more independent by walking to day programs from their group home plus gain exercise from this. Costs are lower with group homes/campus settings when peers can get together from other group homes on campus. Typically, we ALL prefer to socialize with LIKE people. Keeping them closer to each other allows more support and activities to be shared at a lesser cost since no transportation is needed. I see lesser activities in site homes. People/ government think it SOUNDS better, it is not for those at low mild and below MR/ID functioning. Hope Haven campus is on cul de sacs so they are even more safe from traffic. Crime is low. These consumers are integrated in the community 2-4 times a week. The consumers are very happy. They are very safe. I understand a campus setting may be too restrictive by never integrating in the community. This does not happen in our town. This provides security, safety, greater independence. Group homes provide more safety within a building with more regulations, more staff, more peers to select from for activities and companionship. Activities can be cheaper and more fun in groups up to 12. Site homes are double the cost of the group homes. Currently there is not enough govt funding available to cover all people on waiting lists. If we close group homes and force site homes at double the cost we will only serve HALF the people we currently serve, let alone ever get to the wait lists. Please rethink this and allow group homes and campus settings.

The world is changing in such a way that reduces safety to all. Our most vulnerable population is more at risk. Now the government is wanting to end that safety by eliminating group homes and campus settings. Please change this for the good of our special needs family members. It worries me that our fellow mankind is not protecting our family members by allowing them to live in the community in site homes

with staff overseeing them who don't care, have little experience, low pay, no common sense, not dependable, care for their cell phone more than a person or a job responsibility. It may be one of those staff is all the consumers have for an 8 hr period. We could add more staff for an even higher cost. Why, when the group homes have worked so well. Group homes/RCF for no more than 12 people. More abuse takes place in smaller and too large of settings. The settings with 12 or less in a group home is ideal.

This change is not better, it is worse for the people who are lower functioning, low mild/high moderate MR/ID and below. Please help make this change. Stand up and make a difference. (Olson)

RESPONSE: Neither the federal settings regulation, nor the Iowa transition plan sets a limitation on the number of beds, or requires providers to downsize, although some may choose to do so because larger settings may have increased risk of having institutional qualities. With any HCBS provided in a setting that congregates a large number of people with disabilities in one location there is increased risk that the location may have some of the qualities of an institution. We expect that the settings across the state will fall on a continuum from those that need little or no remediation to others that may need extensive remediation. All such locations where HCBS is provided will be assessed for compliance with the regulations. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community.

---

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