

# Disability Rights IOWA

Law Center for Protection and Advocacy™

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*Sent via e-mail to [HCBSsettings@dhs.state.ia.us](mailto:HCBSsettings@dhs.state.ia.us).*

Brian Wines  
Iowa Department of Human Services,  
Iowa Medicaid Enterprise,  
100 Army Post Road,  
Des Moines, Iowa 50315

RE: **Comments from Disability Rights Iowa on Iowa's Home and Community-Based Services (HCBS) Settings Transition Plan**

Dear Mr. Wines:

Disability Rights Iowa, the Congressionally-mandated protection and advocacy agency for Iowans with disabilities, hereby submits its comments to Iowa's Home and Community-Based (HCBS) Transition Plan (the "STP"). DRI envisions a world where individuals with disabilities are free from discrimination and have equal opportunities to live the lives they choose. To this end, DRI believes it is critical that Iowa implements the HCBS settings rule in a way that will ensure Iowans with disabilities are fully included in their communities with opportunities to work in integrated settings, exert control and choice in their own lives and access the community to the same degree as individuals not receiving Medicaid HCBS.

DRI would like to complement the Iowa Department of Human Services (DHS) on the most recent version of the STP. It is much easier to read than the initial plan, is substantive and responds to many of the concerns that the Centers for Medicare and Medicaid Services (CMS) expressed in its September 4, 2015 letter to Mikki Stier, the Iowa Medicaid Director.

However, the STP still needs to be improved in several ways. DRI's major concerns are:

- **Administrative Rule Revisions.** DRI found that the evaluation of the current administrative rules is inadequate and erroneous because the rules continue to allow services to be provided in institutional isolated settings, do not take into account a client-directed planning process and do not reflect the comprehensive transformation of Iowa's Medicaid system to managed care on April 1, 2016. DRI recommends that the review be done by both an attorney and an expert on waiver services and that the rule-making process be delayed for at least six months.

*Our Mission: To defend and promote the human and legal rights of Iowans with disabilities.*

- **Results of Assessments to Date.** STP Appendix A (“Iowa HCBS Settings Based on 2014 Provider Self-Assessment,” should include a column regarding the current level of the compliance of specific HCBS settings with the HCBS Settings Rule.
- **Validation of Provider Self-Assessments.** The validation process of the provider self-assessments should be conducted by an independent entity, rather than HCBS regional specialists or managed care case managers, because they may have a conflict of interest since they need services for their clients even if the services are non-compliant with the HCBS rules. In addition, the plan does not offer much information about how the HCBS qualities are being incorporated into the existing validation and quality assurance process. This should be explained more fully.
- **Iowa’s HCBS Capacity.** There is no mention of examining the current array of settings and needs of the HCBS population to ensure that at the end of the transition period the state can ensure that individuals are offered a non-disability specific setting during the person-centered planning process.
- **Settings that Isolate.** The state has some mechanisms to find settings that isolate, but it is an incomplete plan because it only relies on geographic proximity factors.
- **Competitive Integrated Employment.** The preliminary Provider Self-Assessment questions need to separate residential and non-residential services, such as habilitation and employment services, to get a true picture of whether non-residential settings are complying with the HCBS settings rules. The STP needs to contain a full discussion of how DHS will assess, validate and transition individuals receiving waiver and habilitation services from segregated non-residential services to services that comply with the HCBS Settings Rule.
- **More inclusion of Medicaid members, their families and advocates in the assessment process.** Except for outreach meetings in 2014, the STP makes almost no mention of Medicaid members, their families and guardians or advocates, and is focused almost solely on providers. This exclusion is contrary to the HCBS Settings Rule and has resulted in inaccurate indicators of home and community-based services being used.
- **Corrective Action Plans.** Providers corrective action plans should be available to service recipients, families, guardians and advocates so that they can make informed decisions about their services. In addition, the provider should include milestone dates in the CAPs and the state should be evaluating CAPs on a timeline similar to the timeline of the Department of Inspections and Appeals, rather than through the standard quality review process schedule, which may be one-three years, and as long as five years.

DRI's specific comments are organized to correspond with the specific sections in the STP and are set forth below:

### **Section 1.0 Introduction**

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

### **Section 2.0 Iowa's Statewide Transition Plan (p.3)**

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

#### **Section 2.1.1 Summary of Comments Received**

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

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

#### **Section 2.3.1.1 Administrative Rules**

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

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

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

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

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

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

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

### ***Section 2.3.1.2 Policy Manuals***

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

### ***Section 2.3.1.3 Other Standards***

The STP states that the provider agreements do not directly support or conflict with the settings regulations, but simply state that providers must comply with all applicable federal and state laws. This is too general and does not highlight the HCBS Settings Rule.

Iowa will be transitioning from a fee-for-service Medicaid system to a managed care system on April 1, 2016. Both the agreements that DHS has with the three managed care organizations (MCOs) and the agreements between the MCOs and providers should explicitly require compliance with the Home and Community-Based Setting Requirements if the provider is providing HCBS services. ("HCBS Settings Rule"), 42 C.F.R. § 441.301(c)(4).

### ***Section 2.3.2 Systemic Assessment: Settings Analysis (pp. 16-17)***

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

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

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

### ***Section 2.3.3 Preliminary Provider Self-Assessment Results***

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

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

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

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

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

a. Does Appendix A represent all providers funded through 1915(i) or 1915(c) waivers? Does DHS keep a list of HCBS providers so that it can cross-check the provider's self-identification as an HCBS service.

b. Does Appendix A represent all HCBS providers in the State? If not, how is DHS going to create a complete list?

c. Appendix A list the provider/agency name, location, provider control, type of residence, number of members at the site, and service type. If the self-assessment is being used to determine whether the setting is in compliance with HCBS rules, "self-assessment" of compliance with the HCBS Settings Rules, Appendix A should also preliminarily indicate whether the setting falls into one of the categories below:

1. setting presumed fully compliant with home and community-based characteristics;

2. setting that may be compliant and with changes will comply with the regulation;

3. setting presumed to have institutional qualities but evidence may be submitted to CMS for heightened scrutiny review, or

4. setting that does not comply with the regulations.

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

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

The structure of the charts regarding services and settings analysis are easy to follow. Although the charts list in the aggregate whether providers were generally compliant or non-

compliant in responses to individual questions, the STP does not explain what “compliance” means. Instead of simply stating whether the provider response is “compliant,” the STP should identify the number of settings that fall into the four categories specified by CMS in its September 4, 2015 letter:

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

### **Non-Residential Services**

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

### **Corrective Action Plans (p. 20)**

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

In addition, DHS should provide in the STP its instructions for providers to complete corrective action plans, along with the requirement that the providers give DHS milestone dates for compliance actions.

### ***Section 2.3.3.2 Iowa Participant Experience Survey (IPES) (pp. 22-26)***

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

1. In what specific settings were HCBS recipients surveyed? Residential, non-residential? HCBS compliant, HCBS non-compliant. The survey provides no information about the types of settings in which members responded in the negative. Without this information, it is impossible for the state to determine which types of settings and which specific settings require remediation.
2. Are the 333 individuals surveyed just a sampling? Of how many total individuals?
3. IPES surveys were conducted between July 1, 2014 and June 30, 2015. Were any surveys conducted since June 30, 2015?
4. Who conducted the preliminary IPS survey? HCBS specialists? Case managers? others? What training do the IPES surveyors have to conduct the IPES? If case managers or providers are conducting the surveys, there may be a direct conflict of interest because their priority may be getting services for their clients even if the settings are non-compliant.
5. If members required assistance or reasonable accommodations with the IPES, who provided the assistance or accommodations?
6. How are the survey participants educated so that they know what choices and control that they have and what their rights are?
7. What percentage of the preliminary surveys were actually responded to by a family member on behalf of the participant? Was this family member the individual's guardian?
8. Will the IPES survey be conducted annually for each participant? Will the surveys be conducted after 2018?
9. Will "flags" that are inconsistent with the settings rule be immediately followed up on by the Quality Assurance Unit? (Case managers should not be assigned to do the follow-up because they have a conflict of interest). Is there a written process or time frame in which they are required to follow up with the participant/provider? Will there be documentation kept as to the resolution of the issue flagged in the IPES?
10. What oversight is being provided by IME or its contractors to determine that the IPES is reliable and valid?

In addition, there is no indication that there was a way to tie the participant experience survey to individual settings. Some of the questions in the survey are not useful for the HCBS requirements as they provide the individual no context, such as being a part of their planning process when the rule says the planning process should be driven by the individual. The results of the individual participant survey seem doubtful to the outside reader that they are an

accurate reflection. For example, it seems doubtful that everyone who was restrained actively told someone on their team that they were restrained.

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

- What things would you choose to do?
  - Where you would like to live?
  - With whom?
  - What jobs?
  - What education?
  - What training?
  - What recreational activities?
- What would you like to do to reach your goals?
- Who would you like to help you reach your goals?
- Did you reach your goals?

***Site-Specific Validation Process (p. 28)***

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

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

- a. The survey should be attached to the STP.

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

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

- o Even more concerning are the indicators the group came up with. The first indicator that “The majority of members receive most of their services in a setting that supports access to, and facilitates integration...” is contrary to the regulations and guidance that all of the individuals in a setting must be in a setting that meets the HCBS requirements.<sup>1</sup> (p. 31)

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<sup>1</sup> As indicated in the CMS June 26, 2015 Q&A on Heightened Scrutiny.

### 3. Preliminary Onsite Assessment by HCBS Quality Oversight Unit

- a. The STP repeatedly refers to the HCBS Quality Unit, but insufficiently describes the Unit. How many staff on the HCBS Quality Oversight Unit? What are the qualifications of the reviewers?
- b. What methods are used by the HCBS Specialists to validate the provider's responses? IF HCBS Specialists only look at self-assessments, can this data be relied upon? How do we determine that the self-assessments are complete and accurate?
- c. The plan does not offer much information about how the HCBS qualities are being incorporated into the existing quality assurance process. Because the plan is heavily relying on this for both assessment validation and quality assurance, it should be more fully explained.
- d. The STP states that there will be one year or three year intervals for existing providers and five year periodic reviews once during a five-year period. Five years is a long period of time between reviews. DHS indicates that approximately 40% of HCBS providers will have a site review in any given year. How many on site reviews will have been conducted by the 12/31/16 milestone that DHS has set.
- e. How is the Quality Oversight Unit going to collaborate with the three managed care organizations? How is the Unit going to share information about non-compliance with the MCOs which need the information since they are required to comply with the HCBS settings rules in their agreements with the state?
- f. Will DHS collect any data on which HCBS providers are non-compliant with the settings rules so that it can identify systemic issues?
- g. Again on-site assessments would prove to be more reliable if done by any outside party. MCO Community-Based Case Managers are either employees or contractors of the MCO which presents a conflict of interest. Reliability would be greatly improved if assessment was done by an outside party which eliminates any conflicts of interest.

#### ***Section 2.3.4.1 Heightened Scrutiny***

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

heightened scrutiny and which settings do not have qualities of HCBS and cannot be remediated.

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

### ***Section 2.3.5 Site-Specific Outcomes (Remediation)***

1. **Education and Training (p. 36, #1).** The plan focuses on provider education and involvement and has very little, if anything, on participant and family education. There were initial education sessions in 2014, but no further plans. Education and training is especially needed for members and families in 2018 (before the 5-year grace period ends and non-compliant providers close their doors).
2. **Provider Assessment Findings (p. 36, #2).** The STP indicates that the state will present each provider with the results of the assessment of their HCBS findings as findings occur throughout the assessment process. This information should also be shared with waiver and habilitation service recipients, their families or guardians, advocates and other members of the public so that they can make informed decisions about where to receive services.
3. **Compliance Reviews (p. 36, #4).** The STP states that compliance reviews will follow the normal HCBS quality assurance review cycle, which could be one to three years, and as long as five years. If a provider is non-compliant, the compliance review with the corrective action plan should contain annual milestones for each stage of the remediation process and DHS should review on a yearly basis whether the milestones have been reached.
4. **Sanctions (p37, #6).** Unfortunately, the Iowa Administrative Code does allow DHS to fine providers as a possible sanction for violations of the medical assistance rules. Iowa Admin. Code 441-79.2. The rules should be amended to allow DHS to levy fines to achieve compliance. This has been an effective tools used by the Iowa Department of Inspections and Appeals to get providers to comply. Iowa Admin. Code 481-56.3.
5. **Non-Disability Specific Settings (p37, # 7).** The language of the member transition paragraph only says a “choice of alternative settings” and does not reflect the requirement of having the choice of a non-disability specific setting. In general, the state seems to ignore the part of the rule that requires choice of non-disability specific setting as nothing in the plan indicates the state is examining the array of settings and the needs of the population to determine if it has an appropriate array of settings and can meet the non-disability choice requirement. In general, there does not seem to be an overall shift to more integrated settings. The state needs to continue to develop its

capacity to serve individuals in settings that are integrated into the community and comply with the HCBS Settings Rules.

**6. Alternate funding sources (p37, #7).**

The STP states that “In the event that the state determines that a setting cannot be remediated, alternative funding sources will need to be secured for members choosing to remain in the setting. Below are DRI’s concerns about this provision.

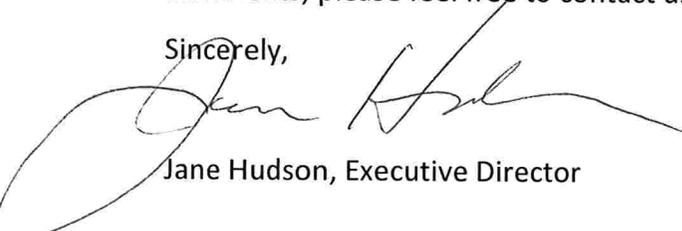
- a. The STP does not say who will secure alternative funding. This should not be the role of an MCO case manager or coordinator.
- b. The plan to secure alternate funding for participants that choose to remain in a noncompliant setting is disturbing because such funding often does not have the same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

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

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

DRI appreciates the opportunity to comment on the STP. If DHS has any questions about our comments, please feel free to contact us.

Sincerely,



Jane Hudson, Executive Director