Public Comments to the Proposed HCBS IDD Waiver Renewal

The Department of Health Care Finance and the Department on Disability Services posted the proposed Home and Community Based Services Waiver for People with Intellectual and Developmental Disabilities (HCBS IDD waiver) for public comment on April 21, 2017 in the DC Register and on the DDS website at: https://dds.dc.gov/page/waiver-amendment-information. DDS and DHCF held a public forum on May 2, 2017 to discuss all waiver changes, as well as a forum focused specifically on rate changes on May 8, 2017. All oral comments received during those forums were incorporated into the public record. In addition, DDS received comments by email and orally.

All public comments received are described and responded to below. Where applicable, DDS and DHCF have modified the proposed waiver renewal accordingly. This document, along with transcripts from the two public forums, will be posted on the DDS website at: https://dds.dc.gov/page/waiver-amendment-information.

HCBS Advisory Group Meeting (May 22, 2017)

Note: This includes comments received at the meeting, as well as follow-up emails received shortly thereafter.

Comment: We recommend that DDS add a higher acuity rate to In Home Supports that would have more QIDDP & Nursing oversight for people who live alone and have higher medical coordination support needs. Current rate includes 12 hours/ year for each RN and Q. For most people, families provide this function. But, for people who live independently, this is an issue because they don't have the natural support and the provider fills in and does this. We note that DDS already uses acuity levels for Host Homes.

Response: DDS agrees and will add the following language to the waiver: In-Home Supports may also be offered as "High Acuity In-Home Supports" for people with more complex medical and/ or behavioral health needs, as evidenced by the Level of Need Screening and Assessment Tool, or its successor, to provide enhanced nursing oversight and healthcare coordination.

Comment: DDS should clarify that In Home Supports can be offered in transitional housing.

Response: DDS agrees that the service can occur in transitional housing, when it is the person's home, but does not believe this requires a change to the waiver. We agree to clarify this through the implementing regulations.

Comment: DDS should modify the service limitations for Skilled Nursing to add authority to extend beyond the 52 visits/ year cap, when required for a person to live in the community. As an example, wound care might require more visits, per year.

Response: DDS agrees and proposes the additions in red:

> The number of nursing visits per calendar year is limited to 52 after all nursing visits allowed by State Plan have been exhausted. Except that DDS may authorized additional visits based upon medical need when required to support a person to live in the community, for example, but not limited to, wound care that would otherwise require a person to live in a nursing facility. Additionally, [o]ne to one extended nursing daily limits can be increased to twenty four (24) hours a day only for an individual on a ventilator or requiring frequent tracheal suctioning, after State Plan daily limits are maximized. Also for an individual on a ventilator or requiring frequent tracheal suctioning, annual limits can be extended with prior approval for up to 365 days after State Plan annual limits are exhausted.

Comment: DDS no longer recognizes Vocational Nurses. This term should be removed from the waiver provider qualifications for Skilled Nursing.

Response: DDS agrees and will remove the references to Vocational Nurses in Skilled Nursing.

Comment: For Wellness services, the provider qualifications for Bereavement services are too narrow. Recommend expanding beyond "professional counselors" with national certification by a specified provider. There are other professionals who offer this counseling, including pastoral counselors, social workers, and nurses. Further, there are more than one national accrediting body.

Response: DDS agrees and will modify the provider qualifications for Bereavement services as follows:

> Bereavement counseling services shall be performed by a person who has been certified by the American Academy of Grief Counseling or other equivalent national certification, as approved by DDS.

Comment: For Wellness services, the provider qualifications for Massage services are too narrow. There is more than one national accrediting body and DDS should recognize the range.

Response: DDS agrees and will modify the provider qualifications for Massage services to add the language in red, below:

> Massage Therapists shall be licensed pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2012 Repl. & 2014 Supp.)) and certified by the National ~~Verification~~ Certification Board for Therapeutic Massage and Bodywork, or other equivalent national certification, as approved by DDS.

Comment: I agree with allowing PCS when a person is at work regardless of residential services. This should apply to school as well.

Response: Agreed. DDS will make add this exception to the concurrent billing exceptions for Residential Habilitation, Host Homes, Supported Living and PCS.

Written Comments from the Quality Trust for Individuals with Disabilities (May 22, 2017)

Comment: I understand from the public forum that the reduction in additional IDD Waiver slots beginning in Year 3 is to account for plans for the upcoming IFS Waiver, which will also be limited to people with ID and their families. It seems unlikely that people with ID – who, by definition, should be eligible for the more comprehensive IDD Waiver – would choose the more limited IFS option, absent a waiting list for the IDD waiver. Such a waiting list would seem likely beginning in Year 3, particularly given 20 slots each year would be reserved for youth transitioning from CFSA and people transitioning from ICFs.

Rather than decreasing the net increase in IDD Waiver slots in Year 3, has DDS considered working with DHCF to create a slot-limited IFS waiver that would be available to a broader category of people with DD, such as autism, who do not also have ID? As QT shared in its DDS budget hearing testimony, many people with autism and their families find themselves to be desperately in need of at least some minimum level of adult services and supports. While DDA may feel that it is currently legislatively constrained to serve only people with ID, DHCF has broader statutory authority under D.C. Code 1–307.02 and 7-771.05(6) as the District Medicaid Agency. It also would seem to be a way to gather better financial data on the cost of expanding DDA service eligibility to people with DD who do not also have ID.

Response: DDS has heard from stakeholders, including our DC Supporting Families Community of Practice, about the need to expand services to people with Developmental Disabilities who do not have Intellectual Disabilities and has done some research and analysis in this area, including a report to the DC Council, available on our website at: https://dds.dc.gov/release/dds-report-committee-health-and-human-services-re-fy16-budget. More recently, DDS partnered with the DC Developmental Disabilities Council to update a Needs Assessment for people of all ages in the District with intellectual and/ or developmental disabilities. The Needs Assessment is available on-line at: https://ddc.dc.gov/page/needs-assessment-2016. We also have begun planning efforts for an IFS waiver for people with IDD, as you note in your comment. However, the FY2018 budget does not include provisions for a waiver that would be available to a broader category of people with DD.

Comment: At the public forum, you indicated that the reason that the Environmental Accessibilities Adaptation and Vehicle Modifications services were being eliminated was because of its historically low and no utilization, respectively. Rather than eliminating these service options, has DDS considered more educational campaigns – for service coordinators, people with disabilities, and the public/landlords -- designed to encourage awareness and greater utilization?

Response: Service coordinators are trained on all waiver services, including the option for a person to use EAA and Vehicle Modification, nonetheless service utilization has been very low

or none. We note that RSA has a similar Vehicle Modification program which also has very low utilization, perhaps because of the robust transportation options in the District, including metro trains, buses and Metro-Access, accessible taxi-cabs, as well as Medicaid funded services like MTM and Supported Living with Transportation.

Taking the place of EAA is the new locally funded Safe at Home Program, which pays up to $10,000 to provide preventative adaptations to reduce the risk of falls in the homes of qualifying seniors and adults with disabilities. Please see: https://dcoa.dc.gov/page/safe-home.

Comment: In the alternative, what about increasing the OTT service limit from $5,000 to current EAA limit -- $10,000, with the possibility of DDS-approved exceptions for additional funds, over a five-year period? At the HCBS waiver regulations committee meeting last week, there was discussion about how EAA related adaptations are incorporated into the OTT service, with the possibility of more flexible timing being built into the OTT payment(s) schedule as well. The current EAA service limitations recognizes the reality that EAAs, tailored to the person, can be more expensive than $5,000.

Response: One Time Transition service can only be used when people are moving out of an institution or facility into a less restrictive setting. While OTT can be used to make needed EAA modifications at the start of a tenancy if such modifications are not of direct medical or remedial benefit to the person, the service cannot be used once a person is established in the home. As noted above, local funds are available for EAA through the Safe at Home program, which pays up to $10,000 to provide preventative adaptations to reduce the risk of falls in the homes of qualifying seniors and adults with disabilities. Please see: https://dcoa.dc.gov/page/safe-home.

Comment: I appreciate that DDS is trying to strike a careful balance in instituting census limitations for day habilitation and employment readiness facilities. However, I question the feasibility of effectively implementing and enforcing the "50/20" rule in practice, given the population of people spending at least 20% of their time at a particular facility may change on a daily basis, e.g., if staff consider it to be "too hot" or "too cold" to go on a regularly scheduled community outing, etc. If DDS picks one date of the month as the census measuring date, what would ensure there are not other days where the facility routinely has well over 50 people there over 20% of the day? It would seem to be administratively cleaner and more easy to enforce a census limitation that is based on a program's total enrollment rather than percentage of time people are at a facility

Response: During the discussions with the HCBS Advisory Group on this topic, as well as through comments on the Statewide Transition Plan, DDS has heard from a number of people about the need for a "launch site" so that families know that their adult son or daughter is going to and will be picked up from the same place every day. We also heard about people with significant medical needs who enjoy being out in the community, but need a place for ADLs, including using a bathroom with an adult changing table, turning, and other therapies.

As DDS has been working with its day habilitation providers to increase opportunities for community integration for every person in the service, some of the larger providers have changed their model so that people are in the community for large parts of the day. DDS

supports this change and does not want to dis-incentivize these providers by limiting their daily census. Likewise, the proposed amendment creates a pathway for the remainder of the large providers to maintain their census if they adjust their practices so that the majority of the people they support are spending a majority of their day in the community

DDS is working on a plan to monitor daily census and time spent in the community and will share it with the HCBS Advisory Group.

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Written Comments from Disability Rights DC (May 21, 2017)

Comment: Many of the changes detailed in the District's new waiver application will allow for more meaningful community integration for District residents with intellectual disabilities. Unfortunately, a significant number of waiver recipients remain in large day habilitation programs, rather than employed or engaged in meaningful day activities. DRDC appreciates the District's work to move away from this institutional level of care, toward individualized and community-based supports, with a focus on the choices and aspirations of people with intellectual disabilities.

Response: Thank you. DDS will continue to work with stakeholders, including the HCBS Settings Advisory Group, which DRDC participates in, to increase and improve opportunities for and utilization of individualized community-based supports.

Comment: Although DRDC recognizes the positive changes in the District's waiver application, we are troubled that the District has again failed to include individuals with developmental disabilities, who do not have intellectual disabilities, in its waiver program. The District is aware and has been for many years about the critical need for supports for adults with developmental disabilities, especially adults with autism and traumatic brain injuries. These individuals do not have access to waiver services or other community-based services. While other states provide supports to people with developmental disabilities, the District continues to neglect this population despite a surplus in the current budget.

Response: DDS has heard from stakeholders, including our DC Supporting Families Community of Practice, about the need to expand services to people with Developmental Disabilities who do not have Intellectual Disabilities and has done some research and analysis in this area, including a report to the DC Council, available on our website at: https://dds.dc.gov/release/dds-report-committee-health-and-human-services-re-fy16-budget. More recently, DDS partnered with the DC Developmental Disabilities Council to update a Needs Assessment for people of all ages in the District with intellectual and/ or developmental disabilities. The Needs Assessment is available on-line at: https://ddc.dc.gov/page/needs-assessment-2016. However, the FY2018 budget does not include provisions for a waiver that would be available to a broader category of people with DD.

Comment: In addition, DRDC is disappointed that the District did not include participant-directed services in their waiver application. Such an option should be available so that people with intellectual disabilities can direct and manage their own supports.

Response: DDS recognizes the need to include options for participant-directed services and has requested and received technical assistance from CMS on this topic. We have begun work on an amendment that would add participant-directed services to the waiver and will include stakeholders throughout the process.

Comment: DRDC supports the addition of Parenting Supports to the District's waiver services. Such support and training for parents with intellectual disabilities is essential to keeping families together and helping parents gain the confidence and skills they need. Such services have been available from Georgetown University's Center for Child and Human Development through a contract with the Department on Disability Services (DDS), and it is DRDC's hope that Georgetown plays a key role in working with the providers who are approved to provide this new service. Georgetown has provided critical supports and assistance to parents with intellectual disabilities and could likely provide valuable technical assistance to the providers of this new waiver service.

Response: Georgetown is welcome to apply to become a waiver provider in this area. As the UCEDD, they also have a key role in providing technical support and capacity building.

Comment: DRDC also supports the use of peers in this service. Peers and other staff, however, must be trained not only in how to teach parenting skills, but also how to navigate through the various District of Columbia child-serving agencies and how to access the benefits and supports available to children in the District.

Response: DDS agrees and will add this to the provider requirements for both peer and professional staff.

Comment: DRDC also supports the addition of Assistive Technology as a new waiver service and appreciates that this service can include service animals, which can provide essential support to people with intellectual disabilities.

Response: Thank you.

Comment: The District states its intention to eliminate Environmental Adaptation Accessibility (EAA) and Vehicle Modification from its available waiver services due to low utilization. DRDC strongly opposes this decision by the District and questions whether the District has conducted outreach to waiver recipients about the availability of these services. Waiver recipients and their family members likely are not aware that such funds exist and/or how to access them. In addition, the process for seeking funds under EAA is onerous, slow and may discourage waiver recipients from seeking these funds as it requires waiver recipients to first

apply for funds from the Department of Housing and Community Development. DRDC suggests that these services remain in the waiver and DDS and DHCF conduct targeted outreach to waiver recipients and their families/guardians to determine the reason for the low utilization.

Response: Service coordinators are trained on all waiver services, including the option for a person to use EAA and Vehicle Modification, nonetheless service utilization has been very low or none. We note that RSA has a similar Vehicle Modification program which also has very low utilization, perhaps because of the robust transportation options in the District, including metro trains, buses and Metro-Access, accessible taxi-cabs, as well as Medicaid funded services like MTM and Supported Living with Transportation.

Taking the place of EAA is the new locally funded Safe at Home Program, which pays up to $10,000 to provide preventative adaptations to reduce the risk of falls in the homes of qualifying seniors and adults with disabilities. Please see: https://dcoa.dc.gov/page/safe-home.

Comment: The District intends to limit Residential Habilitation settings to no more than four persons. DRDC supports this change as smaller settings are more likely to be community-based and provide individualized supports to people with intellectual disabilities.
Response: Thank you.

Comment: Remote Support: The District's new waiver will allow support to be provided through technological means for In Home Supports, Supported Living Periodic and Supported Employment Training and Long Term Follow-Along as long as it is no more than 20% of the time and the person and his/her support team has provided approval. This change allows more flexibility to the waiver recipient and provides oversight and assistance through less intrusive means. It also makes it easiest and is more cost efficient for providers. DRDC recommends, however, if such a service is used, that the District also cover or subsidize the cost of internet service if it is a burden to the waiver recipient.

Response: CMS has not provided guidance on this issue. DC covers internet services using local funds for people who receive Supported Living services and will look at the feasibility of covering this either with local funds for people in the remainder of the services, or, if appropriate, through the Assistive Technology service.

Commented [LE(1]: Laura is checking with Colorado on how they handle this

Comment: The District's new waiver will now permit speech and language services to be offered in the waiver recipient's home, day program or in the community. DRDC strongly supports providing speech therapy (and physical therapy) in the community so waiver recipients can work on and practice his/her skills in a typical community setting.

Response: Thank you.

Comment: DRDC has long-standing concerns about the substantial number of people with intellectual disabilities who remain in large day habilitation programs. Often these programs fail to provide individualized supports to the participants and they spend their days engaged in meaningless, child-like activities such as stringing and restringing beads and coloring.

Therefore, DRDC appreciates the District's restrictions on day habilitation placement in their waiver application. As DRDC has stated previously in our comments to the District's Transition Plan to CMS, we recommend that the requirement that placement in day habilitation programs only occur if other day or employment options have been attempted first apply to **all** DDS consumers, not only those with Level of Need Scores of 1, 2, 3 or 4. Although providing community-based programs and employment opportunities may be more complicated for people with more involved physical or behavioral needs, they must also have the opportunity to live meaningful, individualized and productive lives in the community.

Response: DDS agrees and will extend the limitations for new people coming into non-small group day habilitation services to all people, regardless of LON. This is consistent with our approach to limiting the number of day habilitation hours for all people currently in the service.

Comment: DRDC also appreciates the restrictions on placement in employment readiness programs. Too many people with intellectual disabilities spend literally year after year in these programs, getting "ready" to work. Working on "readiness" skills in a day program setting or facility does not develop the skills needed in an employment setting. These services rarely lead to actual employment. Therefore, DRDC supports placing a restriction on the amount of time an individual can spend in these programs.

Response: Thank you.

Comment: Although the limitation on the amount of time a waiver recipient could spend in a day program or employment readiness program was described in the District's Transition Plan to CMS, the "census limitations" described in the waiver application were not. This addition negates the District's stated intention of limiting large day habilitation programs. This change would allow large day habilitation programs to continue operating, as long as 80% of the participants left the facility during the day. It is silent as to what the participants must be engaged in when they are out of the facility. It is difficult to plan meaningful activities and truly work toward community integration in large programs. That difficulty does not evaporate simply because the staff take some people out of the facility during the day. DDS is well aware, through the Evans litigation and their own monitoring, of the lack of meaningful engagement in the District's large day habilitation programs and this addition will allow the "mind-numbing"[1] activities to continue. It is also very common for day habilitation staff to fail to take participants out when, in their opinion, it is too cold or too warm. Therefore, it is very likely in the winter and in the summer, providers will often have more than 50 participants in the day program

[1] *See* Special Master's Report and Recommendation Regarding Provision of Vocational and Day Services, U.S. District Court of the District of Columbia, Evans v. Bowser, August 16, 2016, Doc. No. 1606 at 39 (describing the activities at large day habilitation programs as "not only mind-numbing in the pointlessness and boredom they depict but life-wasting exercises that rob opportunity from class members who have long been promised community integration").

facility. In addition, the District should be more aggressive in downsizing these programs rather than simply not allowing new authorizations.

Response: The waiver amendment would require that people are out of the building for the majority of the day, allowing time in the facility only for arrival and departure: "However, the daily census does not include people who are in the setting only for morning arrival and afternoon departure and who spend the remainder of their day in the community." During the discussions with the HCBS Advisory Group on this topic, as well as through comments on the Statewide Transition Plan, DDS has heard from a number of people about the need for a "launch site" so that families know that their adult son or daughter is going to and will be picked up from the same place every day.

Both the service definition, implementing regulations, and DDS's Guidance on Individual Schedules describe the requirements for community integration, activities and daily schedules. Further, in terms of improving the quality of services, DDS is engaged in extensive work with 5 of the 7 large day habilitation programs in a process for them to become Person Centered Organizations. The remaining 2 have joined DDS in a national pilot project, led by the Institute for Community Inclusion, on Community Life Engagement. As DDS has been working with its day habilitation providers to increase opportunities for community integration for every person in the service, some of the larger providers have changed their model so that people are in the community for large parts of the day. DDS supports this change and does not want to dis-incentivize these providers by limiting their daily census. Likewise, the proposed amendment creates a pathway for the remainder of the large providers to maintain their census if they adjust their practices so that the majority of the people they support are spending a majority of their day in the community

Comment: DRDC appreciates that the District has clarified that in-home supports may be provided regardless of whether the individual lives in his/her own house, in a family home or with a friend. The District should further specify that such supports can be provided in transitional housing, such as a halfway house or a homeless shelter.

Response: DDS agrees in-home supports may be used in transitional housing, but believes this is already covered by the waiver service definition since this would be the person's residence. DDS will clarify this in the implementing regulations.

Comment: DRDC supports the District's requirement that all new employment readiness providers be enrolled as RSA providers within one year and current providers must be enrolled as an RSA provider within one year of the effective waiver date. This requirement will allow for a seamless transition from RSA to DDA for individuals with intellectual disabilities in need of long-term supports.

Response: Thank you.

Comment: DRDC has concerns, however, regarding the District's intention to alter the experience requirement for staff supporting waiver recipients in Individualized Day Supports (IDS). The District intends to remove the requirement that employees providing IDS[2] have at least one year of experience working with people with intellectual disabilities. Staff who provide IDS services are out in the community without oversight or supervision. They are responsible for ensuring that individuals with intellectual disabilities have meaningful days, learn new skills, interact with people without disabilities and are safe in the community. Considering the level of responsibility and the lack of supervision in the community, the requirement of one year's experience should remain.

Response: Please note that the waiver amendment requires 1 year of experience for staff working in IDS 1:1 with people who have more complex medical and behavioral health needs. DDS disagrees with extending this requirement further, both because of the current reality facing providers in hiring and the need to emphasize matching people with staff who have similar interests.

Comment: The District states that prior to the Individual Support Plan/Plan of Care meeting, the service coordinator must meet with the individual at his/her location of choice or at DDS, depending on which is more convenient. The District should specify that a determination of whether the location is convenient should be made by **the person**, not the service coordinator or other team members.

Response: DDS agrees and will make this addition. It is consistent with the requirements of our ISP policy and procedure.

Comment: System Improvements: This section refers to monitoring reviews by the Evans Court Monitor. As the Evans litigation has been dismissed, all discussion of these reviews should be removed.

Response: DDS agrees and will make this correction.

Written Comments from Family Member CG (May 19, 2017)

Note: Comment is modified to change the person's initials to XX and not identify the providers by name, to further protect the person's privacy. The remainder of the comment is published as received.

Comment: I know today is the deadline for comments on the waiver amendments, and I feel obligated, given our experience, to react again to your plans for employment-readiness (ER) time limitations and suggest that there needs to be more of an "escape valve" for people who may take a bit longer to settle into job preparedness.

[2] The District has kept the requirement of one year's experience for IDS 1:1 although counts lived experience and volunteering as experience. DRDC questions whether lived experience is enough experience to be the only staff in the community with someone who requires significant behavioral support.

I know you have said that employment readiness can be done under IDS, but from 2014 to 2015, when XX was an IDS "guinea pig," [provider 1] showed great reluctance to do something as simple as approaching librarians to help XX get information about the types of jobs people do, and they finally said they could not get reimbursed for that sort of exploration under IDS. This is what caused XX to cut back to one day of IDS hours and initiate ER supports, which started a year ago with [provider 2].

I understand where you're trying to go, and the problems you feel you've had with ER providers. In light of our experience, and finding ourselves one year in with XX's ER provider which has a specific job prospect in mind for him, I do worry, though, about a situation where someone else could be in this situation and DDS would press the "abort" button because of a time limitation.

It seems that DDS has made up its mind on this so I'm probably spitting in the wind. And I realize the clock hasn't started to tick on ER time limitations yet. But our experience shows that things aren't working the way DDS apparently thinks they are, unless there's been a total transformation in IDS which I doubt seriously. As I've also said to you, if XX (or others like him) were to be told he had to "go back" to IDS he would feel he was being demoted or punished – not an impression anyone would want him to have.

Response: DDS appreciates you sharing your son's experience with us. While IDS serves a different purpose than Employment Readiness, it has always been the intent that a provider could do activities like employment exploration in all of the HCBS IDD waiver day services. We have reviewed the IDS service definition and agree to modify it so that it explicitly states that the service may support employment discovery and exploration. Please note that this is already explicitly included in the day habilitation service definition.

DDS is proposing waiver amendments that impose a limit of up to three years for Employment Readiness (with the third year only possible after a break in services). For someone who is already in the service, the time limitation will not begin to run until after the waiver is approved and he has his next ISP meeting Even if a person exhausts the Employment Readiness service, he or she will still have access to RSA and Supported Employment services, and can also develop soft skills and explore employment through all of our day services, as reflected in the implementing regulations.

Written Comments from the DC Coalition of Disability Services Providers:

Comment: One critical area that has changed since the District began to contemplate the terms of its HCBS Waiver Renewal was the issuance of the May 9, 2017 memorandum from CMS Director, Brian Neale. In it, CMS noted the "significance of the reform efforts underway." Director Neale went on to state that, "in light of the difficult and complex nature of this task [compliance], we will extend the transition period for states to demonstrate compliance with the home and community based settings criteria until March 17, 2022 for settings in which a transition period applies. We anticipate that this additional three years will be helpful to states to ensure compliance activities are collaborative, transparent and timely."

Like CMS, we recognize that the changes that are contemplated in attaining a more person-centered and community-based service paradigm are significant. While most states and providers did not appreciate how quickly the window would begin to close from the initial publication of the Final Rule in 2014, the District and its human service providers were moving forward both in response to the proposed CMS changes as well as the pressures from Evans. And while the District, and those persons who benefit from a more individualized and community-based service model, does seem to be further along than many states in attaining compliance, we are concerned about the District's self-imposed "one year from waiver effective date" deadlines that have been included in the renewal application. In calculating those timetables, it appears that DC is seeking compliance by October 2018, well before the revised March 2022 benchmark. We fear that some of the persons receiving supports will be adversely impacted by the pace of change or placed into services that are less than optimal for their needs. We are also mindful of the potential cost ramifications of more individualized services in an environment that may see per capita caps for services within the District. The cost implications of such a scenario would be devastating. The Coalition has testified to our concerns about the increased costs at both the recent Committee on Health and the Committee on Human Services DDS and DHCF Budget Oversight Hearings.

Response: DC has been engaged in a multi-year effort to increase the capacity of the service system to provide person-centered high quality HCBS in the least restrictive setting. We believe this systems change initiative has well situated the District to achieve compliance with the HCBS Settings Rule. Although we appreciate that CMS is offering states more time, if needed, DC has submitted a Statewide Transition Plan to CMS for final approval and intends to work towards to achieve the timeframes within.

The waiver renewal proposes that any new setting be compliant with the HCBS Settings Rule at the time it is established. Further, it would require that all residential settings be in compliance by the time the waiver is renewed, in November 2017. DC believes this is reasonable because this has been the expectations in our regulations for more than a year, and Provider Certification Review (PCR) is already testing for compliance in this area. A review of aggregate PCR results for residential provider compliance with the HCBS Settings Rule requirements shows that the great majority of providers are in compliance with most indicators. When a provider fails an indicator, they must do a Plan of Correction and remediate, ensuring that providers are taking action to come into compliance with the HCBS Settings Rule.

For day settings, DDS has proposed September 2018 as the latest date for which we would seek full compliance with the HCBS Settings Rule, however, we already require compliance with most provisions by regulation and monitor this with PCR. We will work with the HCBS Settings Advisory Group on which additional requirements to add to the implementing regulations for November 2017.

Finally, the Appendix J reflects our estimates for which services people may choose as alternatives to Day Habilitation and Employment Readiness and the costs continue to be cost neutral and within our fiscal constraints.

Comment: [W]e urge the District to reconsider the timeline for the discontinuation and caps for certain services and acuity limitations. For example, Appendix C: Participant Services - C-1/C-3: Service Specification establishes an implementation date pursuant to its newly added day habilitation service definitions language: "Service limitations for people *currently* in Day Habilitation services: (1) Within one year from the waiver effective date, any person with a Day Composite score of 1 or 2 would no longer be eligible for Day Habilitation services and services may no longer be authorized…" and "(2) Within one year from the waiver effective date, regular Day Habilitation services may not be authorized for any waiver participant with a Day Composite Level of Need score above 2 for more than 24 hours per week, subject to the exceptions described below…." p. 65 and for *new admissions* "(1) Within one year from the waiver effective date, any person with a Level of Need Day Composite score of 1 or 2 would no longer be eligible for Day Habilitation services and services may no longer be authorized…" and "(2) Within one year from the waiver effective date, regular Day Habilitation services may not be authorized for any waiver participant with a Day Composite Level of Need score above 2 for more than 24 hours per week, subject to the exceptions described below…." p. 66. The service specifications go on to establish service hour limits and Level of Need caps for Employment Readiness and other day services.

We would suggest that it might be wise to slow the pace of change with a longer period for concurrent service options, a slower phase out for persons with lower LONs and allow the market to develop the desired community-based services while also committing more resources to enhance employment options within the District since employment would be a preferred outcome.

Response: DDS disagrees. We have been investing in alternative community based options for several years, including Individualized Day Supports and Companion services and have sufficient providers to absorb the change in services. We also have sufficient supported employment providers as well as a strong relationship with RSA.

Comment: Contained with the Renewal Application are proposed changes to Appendix A: Waiver Administration and Operation / Quality Improvement: Administrative Authority of the Single State Medicaid Agency, specifically, the Performance Measures. The District has proposed to delete the following Performance Measures:

> "Percentage of participants who received services in accordance with the service plan including the type, scope, amount, frequency and duration specified in the service plan. N/D N = number of people that receive services described in the ISP in type, amount, duration and frequency D = Total number of people who received service coordination monitoring visits." p. 33

> "Percentage of participants whose service plans contain documentation that they were afforded choice between and among waiver services and providers, N/D N = number of service plans (ISPs) reviewed that include documentation. D = number of ISP reviewed." p. 34

The DC Coalition would suggest that the measures are valuable and should not be eliminated in the renewal application. We see this as a check and balance not only designed to protect the individual receiving supports but also the follow-through for Service Coordination staff. Likewise, we appreciate the detailed Service Coordinator expectations as described on p. 166 in Appendix D: Participant-Centered Planning and Service Delivery - D-1: Service Plan Development and we would urge the District to include a separate Performance Measure that evaluates adherence to the expectations of Service Coordinators to ensure compliance.

Response: DDS agrees to reinstate the two performance measures described above. However, we disagree with the recommendation to include a new performance measure that evaluates adherence to the expectations of service coordinators. DDS already measures the performance of service coordinators through annual performance plans, as well as an annual service coordination audit, conducted by a third party contractor, which we share publically.

Comment: Because all of the residential, supported living, day services, respite and peer support rates build from the hourly rates allocated for Direct Support Professionals ("DSP"), it is important to address the concerns that arise from the disparity within these building blocks.

In the District's rate calculations, respite care services - which carry training and performance expectations consistent with any other community-based support - are based upon an hourly DSP rate of $12.85/hr - a rate that is below the District's Living Wage. DSPs who provide respite services are the very same trained staff as are utilized by providers for other services. If the District seeks adherence to a Living Wage for workers within this labor classification, the $13.95/hr rate should apply to the base wage for respite.

Response: DDS agrees. While the Living Wage is not legally applicable to the Respite service, we recognize that practically speaking, it is the same residential staff working in Respite. We will adjust the rate accordingly.

Commented [LE(2]: Pending cost analysis

Comment: Equally concerning is the proposed base hourly rate for the new Family Training/Peer Support service at $18.40/hr - which require limited training but significantly exceeds the In-Home/Residential base DSP of $13.95/hr.

Response: DDS disagrees. Peer employees have a different skill set from DSPs. This is a new class of employees and we believe it is important to be consistent with the Bureau of Labor Statistic so that providers will be able to attract these employees.

Comment: Productivity accounts for hours when staff must perform duties that prevents them from providing direct services. And while the productivity factor that was used in this renewal has decreased (from 1.2% to 1.13% in Supported Employment, for example) it appears the renewal contemplates no reduction in the amount of work required to perform services under the waiver. To the contrary, the waiver renewal mandates heightened training requirements for all DSP staff in a more individualized, person-centered platform which will include additional provider monitoring. The Coalition suggests that the productivity factor - which is a component of rate setting - should be increased in the renewal, not decreased.

Response: The waiver renewal does not mandate heightened training requirements for DSP staff or additional provider monitoring. Despite multiple requests during the time we were drafting the waiver and public comment periods, the providers have not brought forth documentation demonstrating actual productivity. We would welcome this information and, once received, will consider adjusting the rate methodology, subject to public comment and CMS approval.

Comment: Further, the Coalition surveyed its members regarding the program oversight assumptions for QIDPs, RNs and House Managers in order to provide data to aide in the District's rate calculus. Over the last four (4) days we have been able to secure a 34% Coalition member response rate as it relates to the annual engagement assumptions that the District contemplated in the development of its proposed rates. In all circumstances: Supported Living (Qs); In-Home (Qs); In Home (House Managers); In Home (RNs); Host Home (Qs); Host Home (House Managers); Respite (Qs); and Respite (RNs), the average number of annual hours for each professional within each service greatly exceeded the assumptions implicit in the District's proposed rate calculation.

The following chart summarizes our findings:

Service	Indirect/Program Job Classification	Annual Hrly Assumption	Actual Annual Usage
SL	QIDP	12 hrs/yr	48 hrs+/yr *
In Home	QIDP	12 hrs/yr	48 hrs/yr
	House Mgr/Supvr	35 hrs/yr	59.5 hrs/yr
	RN	20 hrs/yr	27.4 hrs/yr
Host Home	QIDP	12 hrs/yr	42 hrs+/yr **
	House Mgr/Supvr	18 hrs/yr	52 hrs/yr
Respite	QIDP	5 hrs/yr	45 hrs+/yr
	RN	7 hrs/yr	37.5 hrs+/yr

N = 17 providers/ services represented ranged from 6 to 16 providers offering the specific service.
Data is based upon providers that fall within all eight (8) of the DC Coalition's annual budget levels from the smallest (with annual budgets of less than $500K) to the largest (with annual budgets of greater than $10M).
* 13 of 16 respondents that provide SL services indicated that "4 or more hours" of engagement per month were required for proper oversight from their QIDPs
** 6 of 6 respondents that provide Host Home services indicated that "3 or more hours" of engagement per month were required for proper oversight from their QIDPs

We attribute some of this disparity to the level of monitoring in DC and the amount of time that staff must spend with monitors outside of their regular work. Other factors that contribute to this are a number of other requirements, including but not limited to, financial oversight, medication management oversight, incident management, rule requirements for required paperwork, and staffing issues – including onboarding new staff and training – all of which takes a significant amount of time that is not accounted for.

Response: Thank you. It would be helpful to see cost data (your books) supporting this. DDS requested this during the time we were formulating rates and during the public comment period. Once available, DDS will consider amendments to rate methodologies, subject to public comment and CMS approval.

Comment: [F]or Individualized Day Services, the decrease in indirect front line manager hours from 75 hours per year to 52 hours per year is unrealistic considering the additional documentation that is required for each person supported.

Response: DDS agrees to reinstate the hours to 75/ year. This is a service we expect to grow under the waiver renewal and understand the need for this level of frontline supervision.

Commented [LE(3]: Pending cost analysis

If we do this, in the regs we could include requirements for certain amount of actual supervision in the field

Conversation with IDS Providers after the Forum Ended (May 8, 2017)

Comment: DDS should eliminate the requirement that the IDS individual staff person cannot work at both the residential provider and do IDS for the person. Sometimes, that is the staff who knows the person best, especially given the high staff turnover in the field. Operationally this is difficult to track since DSPs often work for different providers.

Response: DDS agrees, in light of the staffing pressures, and will make this change.

Conversations with Project ACTION! Members (Various Dates During Public Comment Period)

Comment: Recommend that Parenting Supports and Family Training should not require certification for all peers, because this might disqualify too many people with I/DD who have important experiences to share. There should be an alternative option based upon their experience so more people can be peers.

Response: DDS agrees and will add the following additional option:

> Have lived experience as a parent with a disability or the parent/caregiver of a person with a disability that includes at least two of the following:
> (1) Advocating on behalf of people with disabilities;
> (2) Be trained in advocacy on behalf of people with disabilities by an advocacy organization;
> (3) Be trained and certified in peer counseling by a certified peer counseling organization;
> (4) Knowledge of the DC CFSA and DC DDA scope of services
> (5) Skills in Engagement, Relationship Building, and Collaboration with Families and Caregivers
> (6) Knowledge of Community Systems, Partnerships and Resources

Comment: What changes are happening for people who live alone in their own apartment. He We know people who live alone and who are saying they're being forced to have a roommate and they don't want a roommate.

Response: The proposed waiver changes require that all residential providers comply with the HCBS Settings Rule, which includes a provision for choice of roommate. If a person has the financial means to live in their own apartment that is an option as well. For people who cannot afford this, unless there is a documented medical or behavioral reason for the person to live alone, the District is not able to provide every person with their own apartment.

HCBS IDD Waiver Renewal Public Forum on Rates (May 8, 2017)

Comment: For supported living periodic, the rate is $24 and some change, but you are expected to have RN support and for people who need an RN, for example to pass meds, you are paying $38 or $40 per hour for an RN, but the billable hour is much less. This is true when a person needs supports from the QIDDP or House Manager as well.

Response: Time for those staff members are built into the rate, but we need feedback on whether we have the right assumptions for the number of hours for those staffing supports. The majority of medications can be passed by Trained Medication Employees and do not require an RN. Where RN services are required, this is available through the state plan.

Comment: The RN salary of 36.98 in the rates is too low for an RN, unfortunately these days. We are paying $38 or $40 an hour for RNs.

Response: The salary for an RN is based upon the rates for RNs in the ICF program, so that there is parity between the programs. If there are changes to the RN salary as a result of the current ICF rebasing efforts, we plan to amend the waiver to likewise change that within the waiver.

Comment: For services that are billed by the hour, and specifically for Supported Living Periodic, the rates doesn't really factor in any of the management time, nursing time and all of those. Because it is specifically built on the direct service hours a person receives.

Response: The rate for SL Periodic does include a portion of time for RN, House Manager, Trainer, Q, administrative, etc. It would be helpful to know if in your experience you use more time than is included in the rates for those supports.

Commented [LE(4]: LLN will send us rates from VA and MD to compare. NOVA does pay more for this service.

Comment: We lose money every year on Supported Living Periodic services and our board is asking whether we ought to continue to provide this service.

Comment (2nd provider): We have had to discharge people who are in Supported Living Periodic because we could not support them with the rate.

Response: This is an area in which we need to see your cost data so that we can make adjustments if needed to ensure access to the service.

Comment: The House Manager at 35 hours and Q at 12 hours is just too low given the level of monitoring and regulatory requirements.

Comment: The benefits factor of 20% is too low. We can provide data on that.

Response: In the 2015 data, we received public comments asking us to increase the benefits factor to 22% for day programs, but that the increase did not apply to residential programs because there were less full time staff. We did make that increase to day programs in 2015. Is it the case now that residential services also have an increased benefit cost?

Comment: Yes, costs are around 22% or 23% across day and residential services.

Response: Thank you. It would be helpful to see cost data (your books) supporting this. Additionally, the ICF cost reporting includes evaluation of the cost of employee benefits and can inform this as well.

Comment: 30 hours of Q time for professional supported employment is very low.

Response: Thank you. It would be helpful to see cost data (your books) supporting this.

Comment: IDS 1:1 continues to need an absentee factor, particularly for people who live at home and are dependent on MTM transportation. We have cases where people are not coming to program because MTM is not showing up and their authorization expired and we didn't know about it. So we are often paying staff a couple of hours for showing up but the person doesn't show. It is less a problem when people are coming from homes with they are living with transportation. Also, when people are late for the service, you have to pay staff to wait for them, but can't bill for that time.

Response: IDS 1:1 can start and end at the person's house. DDS encourages providers to consider that option, which eliminates the dependency on MTM.

Comment: For respite, the hourly wage is $12.85. But we are using the same folks that are providing the rest of the residential services to do that and they are at the living wage of 13.95. Moving forward and most of the time for respite you can get killed on that rate because you get a call within minutes or hours, "I need respite" so I don't have people sitting already that are paid at $12.85, they are at the living wage.

Response: That makes sense. We will increase the base DSP rate in Respite to match the living wage, so that it aligns with other residential services.

Commented [LE(5]: Pending cost

Comment: For Host Homes, we need additional hours for managers and nurses. The provider is responsible to make sure the host family is doing everything that they need to do, that they are reporting incidents and if an incident happens your time is already blown because you have to investigate it. Then we are responsible for finances, which is a nightmare, very consuming because you have somebody who is spending people's money. And most of these host families are older, used to the old foster care system where they didn't have to account for anything. Getting receipts out of people is like tracking down a mountain on a molehill.

Same thing with nursing, which is responsible for medication management. You have to go every month, you have to make sure people are getting their meds and you have to see what is in their med box and you have to watch. So it feels like the numbers are low.

Response: Thank you. It would be helpful to see cost data (your books) supporting this.

Comment: I think another thing to factor in is we do have support workforce crisis. So I know us as an agency, and I know we are not alone, our managers and Qs and program manager, house managers spend a lot of time every week interviewing new staff, training new staff. That is a weekly, ongoing thing. So on boarding and training is definitely -- well, I know you increased it by 50 percent but I don't think it captures the reality of the workforce crisis and we are constantly working from behind. I know our over time factor is very high because of that. Plus, when you are staffing people specifically periodic and in home supports when you are writing adds specific to these folks, for example, they live in a specific part of town and have dogs. \So you are specifically interviewing for one person. It is not like you are interviewing a whole group and say, "Oh, this person will work over here.." That is unfortunately not the way it works. So we spend a lot of time and matching is huge. I know our HR just doesn't -- they can't do the matching like the managers can. So they can hire what they think is good staff, but then our managers still spending time matching.

Comment (provider 2): I will piggyback comment. XX is saying exactly everything that is happening across the board. It is something we talk about as a provider coalition constantly and even for us the house managers and program coordinator. The Q level folk, they are trying to match because we are trying to meet the demand making sure the -- the staff person is appropriate to the person served from the regulations. So the staff person, the potential staff person is out meeting with the person served and the house manager and the Q so identify if I like them or not. Is this going be a successful match or not to then go and train them. And the family participate and most of the time the families say, "Nope, don't like them," And you keep sending tons and tons and tons of potential employees to the circle of support to interview the staff person this is what I would call on boarding. This is just navigating who is potentially going to look good to work with me and I still have not passed a background check and all the other things that would need to be cleared prior to me. They are spending quite a bit of time doing these, just speaks to the low number. And it doesn't account for meeting the demands.

Response: DC already provides an administrative rate factor of 13%. This is higher than the CMS model rate factor of 9% and our neighbors in Virginia, which use an 11% factor. DDS would be open to considering an increase, subject to cost reporting. (For the CMS model, please see: https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1a-ffs-rate-setting.pdf.)

Comment: Are there any incentive for providers to become more electronic? Because that is cost efficient and increases productivity.

Response: Not specifically, although there is an administrative portion of the rate. CMS has provided incentives for healthcare vendor but not for long term care service providers.

Comment: Given the nursing crisis, and the rate paying less than market, how so we attract more of which there is less when rates are lower than the average they are paying?

Response: The nursing rates were raised a couple of years ago, trying to address the nursing staff crisis, and they have since been inflated. The ICF rebasing should establish new rates and

we plan to do a waiver amendment to align the salaries within the rate methodologies for positions like nursing.

Comment: I noticed the hours are very small for the nurses that are allowed. We are -- hospitals are moving people back in the homes to be taken care of. So we have to account for nurses to take care of people in the home.

Response: The nursing hours in the rates is intended to be oversight and not direct support. The person can still use state plan skilled nursing services and there are extended hours available through the waiver, if needed. Additionally, there is a Supported Living with Skilled Nursing service if the person needs that level of supports.

Comment: A lot of times you have people in the hospital, the provider can't take them and they don't qualify for a SNF. The respite hours for nursing are low for medically fragile people in the home. Is there any discussion about building a respite service for those situations?

Response: We did look at creating a respite service for when people are coming out of the hospital and they were not able to get the support they needed in their home. But, instead we want to focus on work with current providers and our service coordination staff so that people are able to return to their own homes, with the staff who know them best, and with the levels of support they need, through the waiver and state plan.

Comment: I had an incident with host home, where there are also not a lot of nursing hours in the rate and the person was coming home from the hospital with a fresh surgical wound.

Response: The person is eligible for Medicaid state plan nursing services. What you are seeing here is hourly rate services, which covers nursing medication, administration, the care plan, helping coordinate some healthcare. It is not direct care nursing. The situations you are talking about should involve state plan skilled nursing.

Comment: If someone is in a supported living and they need finger sticks, or psychiatric medications, they need a nurse to come by twice a day because the TME cannot do it. That is a lot of extra time for the nurse.

Response: Again, as a direct skilled nursing service, this should be coming from state plan skilled nursing, not the nurse accounted for in the rates for this service.

Comment: The training policy says only RNs can train and that involves a lot more hours for nurses because any time the HCMP changes, then the RN must come out and train. That should be considered.

Response: The training policy only requires RNs to do initial training, for example, to the Q or House Manager, who can then train direct support staff.

Comment: DDS Health and Wellness monitors expect to see this training done by RNs.

Response: We will follow-up directly with them to correct this and align the monitoring to our policy requirements. Please let us know right away when you are seeing things that do not make sense to you so that we can correct them in real time.

HCBS IDD Waiver Renewal Public Forum (May 2, 2017)

Comment: Will a person be able to use Assistive Technology to buy a service animal? I support that.

Response: Yes, if it is within the cap.

Comment: Is it a federal requirement to limit the size of Day Habilitation and Employment Readiness facilities?

Response: No, there are no federal census restrictions for facilities. However, there is a requirement for both day and residential services that people are integrated into the community.

Comment: Is making people go into the community a federal requirement?

Response: The federal Home and Community Based Settings Rule contains an outcome-oriented definition of home and community-based services (HCBS) settings. The purpose of the federal regulation, in part, is to ensure that people 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 people who do not receive HCBS.

Comment: Will you lose Medicaid funding if you do not comply?

Response: Yes. CMS expects all states to develop an HCBS transition plan that provides a comprehensive assessrment of potential gaps in compliance with the new regulation, as well as strategies, timelines, and milestones for becoming compliant with the rule's requirements. DC's Statewide Transition Plan is available on our website at: https://dds.dc.gov/page/waiver-amendment-information.

Comment: When do the limitations on Employment Readiness begin to run for people currently in services?

Response: The service limitation begins to run at the time of the person's first ISP meeting after the waiver renewal is approved.

Comment: How many people who are in Employment Readiness services actually get a job? In my experience, it is none.

Response: While some people have gotten jobs through this service, we agree that the number is lower than we would expect. That is one of the reasons for the time limitation for this service. The purpose is to teach the person the skills they need to get a job and do discovery and exploration about what jobs would be a good fit. If a person continues to use this service year after year, then it is not helping the person achieve his or her employment goal.

Comment: Is RSA getting people with IDD jobs?

Response: Yes, but it is an area we are focused on improving over the coming year.

Comment: Are there lessons to be learned from states who are doing better than DC in employment?

Response: Yes, and we are always working on that through our membership in the State Employment Leadership Network, and participating in the Administration on Intellectual Disabilities' Employment Learning Community and the Department of Labor Office of Disability Employment Policy's Employment First Leadership Mentoring Program.

Comment: We are faced with the expectation that everyone can work, but not everyone has the skills to go to an interview and be successful.

Response: This is where you come in, as a provider, to use discovery to determine the person's strengths and support needs, and consider a customized job opportunity.

Comment: We are being pushed that everyone has to work, but not everyone wants to work.

Response: While we want to encourage each person of working age to explore employment and ultimately work in competitive, integrated employment, it is still the person's choice and the HCBS IDD waiver offers a full array of day services for people who do not work.

Comment: Is DC a model employer of people with disabilities?

Response: DC is working on this. We already have an Employment First Mayoral Order. Now we are developing a paid internship program for people with disabilities to work throughout the DC government. We already have one such person interning at DDS.

Comment: What are people's options now that you are cutting day services?

Response: In addition to Day Habilitation, DDS offers a variety of day options, including Individualized Day Support, Employment Readiness, Supported Employment and Companion, combined up to 40 hours per week. Plus, a person can use non-waiver services like vocational rehabilitation services, as well as generic community supports.

Comment: It is important that we educate people realistically about jobs so that they know what the job entails and whether it is a good fit for them.

Response: DDS agrees. This is part of employment exploration and discovery. It is an allowable activity under all of the day services in the HCBS IDD Waiver.

Comment: There is too much use of psychotropic medications, instead of active programming in day services.

Response: DDS prohibits the use of psychotropic medications as PRNs or for staff convenience. Psychotropic medications is reviewed in a variety of ways, including through the Restrictive Controls Review Committee. If there is a person you are specifically concerned about, please let us know and we will investigate their situation.

Comment: How many people that DDA supports are on psychotropic medications?

Response: According to the National Core Indicators (NCI) survey, 33% of respondents from Washington DC reported taking at least one medication for mood disorders, anxiety or psychotic disorders. This is lower than the average across NCI states of 49%. Please see: http://www.nationalcoreindicators.org/upload/core-indicators/2014-15_ACS_Washington_DC_Report.pdf.

Comment: Other than the rates that decreased, did the all of the other rates increase by 2.5% of the component related to actual staff?

Response: No, we applied a projected Consumer Price Index of 2.5% to the entire rate, not just the staffing component.

Comment: Once the ICF rebasing is done, will the waiver rates go down?

Response: It is too early to predict the outcome. Once we have the rebasing data available, we will recalculate the waiver rates, and, if we want to move forward with them, publish them for public comment prior to submission to CMS.

Comment: When will the ICF rebasing information be available?

Response: October 2017.

Comment: We need a definition of what community integration means so that we understand expectations.

Response: Per the Statewide Transition Plan, DDS plans to revise its Most Integrated Community Based Settings policy. We will endeavor to create more clarity through that policy. Stakeholders will have an opportunity for feedback on the policy prior to it being finalized.

Comment: Why are so few people being court committed?

Response: DC law only requires court commitment when a person with certain levels of intellectual disability enter into a facility-based residential setting. We find that most people and

their support teams either are living at home independently or with families, or are selecting our less restrictive options: Supported Living and Host Homes. Those services do not require court commitment.

Comment: Does the ICF rate include day services?

Response: Yes, it is an inclusive rate.

Comment: What is the current ICF rate?

Response: It depends on the person's acuity level. The chart in Appendix J shows average cost and demonstrates that it is less expensive to serve people though the HCBS IDD waiver than in an ICF setting.

Comment: Who can I talk to if I am concerned about a person's psychotropic medication use and want a review?

Response: Matthew Rosen: matthew.rosen@dc.gov

Commented [LE(6]: Jared, we should update this. Whom should we list?