Department of
HUMAN SERVICES

Iowa Home- and Community-Based Services (HCBS) Final Settings Statewide Transition Plan (STP)

October 2019

Iowa Home and Community-Based Services
Final Settings Statewide Transition Plan

I. Summary

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for Home and Community-Based Services (HCBS) that requires the state of Iowa to identify all residential and nonresidential settings where HCBS services are provided for the purpose compliance with the final rule. Once identified, Iowa is required to establish a systematic process to review and assess the settings where members receive HCBS services to determine if each setting complies with the final rule. For settings that do not initially comply, the state must identify how each setting will come into and maintain compliance with the final rule. For setting that cannot come into compliance, the state must establish a process for the timely transition of members into in settings that meet the HCBS settings requirements.

Settings that are HCBS compliant with the final rule must be integrated in and support full access for individuals receiving Medicaid HCBS to the greater community, including 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 of access as individuals not receiving Medicaid HCBS.

II. Purpose:

The State of Iowa submitted an initial Statewide Transition Plan (STP) to CMS in March 2016. CMS provided feedback and identified required changes prior to initial approval. Iowa took the needed steps to address the technical corrections identified by CMS and was given approval of the initial STP on August 9, 2016.

In the initial STP approval letter, CMS identified five actions required of Iowa to receive final approval:

- Complete comprehensive site-specific assessments of all HCBS settings, implement necessary strategies for validating the assessment results, and include the outcomes of these activities within the STP;
- Draft remediation strategies and a corresponding timeline that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identified by the end of the HCBS rule transition period;
- Outline a detailed plan for identifying settings that are presumed to have institutional characteristics, including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating those settings and preparing for the submission to CMS for review under heightened scrutiny;
- Develop a process for communication with beneficiaries that are currently receiving services in settings that do not or will not come into compliance with the HCBS setting rules by March 17, 2019 (now by March 17, 2022 per CMS extension); and
- Establish ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

This final STP has been written to address the CMS issued identified above, reviewed internally by the IME and STP stakeholder committee, posted for public comment, reviewed and modified based on public comments and will be submitted to CMS for final approval on or before November 25, 2019.

III. Iowa HCBS Background

The final statewide transition plan applies to all HCBS programs within the state, including Iowa's seven 1915(c) HCBS Waiver programs and the 1915(i) State Plan HCBS program known as HCBS Habilitation Services whether provided through the Fee-For-Service (FFS) delivery system or through a Managed Care Organization (MCO). This includes any additional home and community-based services such as "value-added" or 1915(b)(3) services provided through an MCO.

HCBS Habilitation Services – provides services and supports for Iowans with the functional impairments typically associated with severe and persistent mental illnesses. There are no age limitations for this program.

AIDS/HIV Waiver (CMS Waiver # IA.0213) – provides services for persons who have been diagnosed with AIDS or HIV and who meet the hospital or nursing facility level of care. There are no age limitations for this program.

Brain Injury Waiver (CMS Waiver # IA.0299) – provides services for those who have been diagnosed with a brain injury due to an accident or illness and who meet the nursing facility, skilled nursing facility, or ICF/ID level of care. Members must be at least one month of age.

Children's Mental Health Waiver (CMS Waiver # IA.0819) – provides services for children who have been diagnosed with serious emotional disturbances who meet the hospital level of care. Members must be under 18 years of age for this waiver.

Elderly Waiver (CMS Waiver # IA.4155) – provides services for older adults. Members must be at least 65 years of age and who meet the nursing facility or skilled nursing facility level of care.

Health and Disability Waiver (CMS Waiver # IA.4111) – provides services for persons who are blind or disabled and who meet the nursing facility, skilled nursing facility, or ICF/ID level of care. Members must be less than 65 years of age for this waiver.

Intellectual Disability Waiver (CMS Waiver # IA.0242) – provides services for persons who have been diagnosed with an intellectual disability and who meet the ICF/ID level of care. There are no age limitations for this program.

Physical Disability Waiver (CMS Waiver # IA.0345) – provides services for persons who are physically disabled who meet the nursing facility or skilled nursing facility level of care. Members must be at least 18 years of age, but less than 65 years of age.

IV. Overview

The final settings rule requires that all HCBS settings be integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The rule also requires that each setting:

- Is integrated in and supports full access to the greater community
- Is selected by the individual from among setting options

- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices, and
- Facilitates choice regarding services and who provides them.

The final rule make distinction between settings where HCBS services may be provided. Included are:

- Settings that are not HCBS
- Setting presumed not to be HCBS
- Settings that could be in compliance with the final rule with some modifications
- Setting presumed to meet the final rule without any change required

Settings that are not HCBS

Certain settings are considered not to be HCBS and as such, HCBS services cannot be provided in those locations. Settings that are not considered HCBS include:

- Nursing Facilities (NF)
- Institutions for mental disease (IMD)
- Intermediate care facilities for individuals with intellectual disabilities (ICF/ID), and
- Hospitals

Setting presumed not to be HCBS

The final rule identifies settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. Iowa may only include such settings in its Medicaid HCBS programs if the setting has completed a comprehensive settings review by the Iowa's HCBS Quality Improvement Oversight (QIO) Unit and is in full compliance with the HCBS setting rules by July 1, 2020. If the setting is not in compliance by this date, Iowa may only include the setting in its Medicaid programs if CMS determines through a heightened scrutiny process, based on information presented by the state and with input from the public, that the state has demonstrated that the setting meets the qualities for being home and community-based and does not have the qualities of an institution.

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

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

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

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

As noted above, these settings are presumed to not be community based unless they come into compliance with the final rule by July 1, 2020. All settings requiring a heightened scrutiny review must be identified and reviewed by the state and submitted to and approved by CMS by March 17, 2022 in order to receive continued HCBS funding in that setting.

Settings that could be in compliance with the final rule with some modifications

Some residential or non-residential setting could be in compliance with the HCBS settings rule with some modification to the operation of services of the provider. Each setting is identified by the HCBS QIO Unit and reviewed for compliance with the rules. Providers that have an identified compliance issues will develop a corrective action plan (CAP) to identify how the provider will come into compliance. A CAP may require:

- Changes at the provider organizational level (i.e., policy and procedures)
- Changes in the member's person centered plan
- Providers will be in full compliance by March 17, 2022, in order to receive HCBS funding in service setting.

Setting presumed to meet the final rule without any change required

There are settings where HCBS services can be provided that are presumed to meet the HCBS settings rules. These settings, by their nature, indicate that the setting is fully integrated into the community. These settings include:

- Member owned homes
- Members living in their family home
- Integrated community rental properties available to anyone within the community
- Individualized supported employment
- Individualized community day services

Provider-owned or controlled settings

In addition to distinguishing where HCBS services may be provided, the final rule also includes provisions for provider-owned or controlled home and community-based residential settings. Provider owned or controlled homes are identified as a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The requirements for provider owned or controlled homes include:

- At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to

provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.

- Each individual has privacy in their sleeping or living unit. This includes having entrance doors to the member's living and sleeping unit which can be locked by the individual with only appropriate staff having keys; individuals having a choice of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.
- Individuals have the freedom and support to control their own schedules and activities, including having access to food at any time, and having visitors of their choosing at any time.

These requirements may only be modified when an individual has a specific assessed need that justifies deviation from the requirements. In such cases, the need must be supported and documented in the person-centered service plan.

V. State Assurances:

The State assures full and on-going compliance with the HCBS setting requirements at 42 CFR Section 441.301(c) (4) (5) and Section 441.710(a) (1) (2) and public input requirements at 42 CFR 441.301(6) (B) (iii) and 42 CFR 441.710(3) (iii) within the specified timeframes for the identified actions and deliverables. While the State is already compliant with some of the requirements, the State will reach full compliance by implementing a statewide transition plan as described below.

The State assures that, as the standards and the plan for transition are developed, the public has an opportunity for input. The State will consider those comments and make revisions to the plan, as appropriate, before the plan is considered final.

VI. Public Notice and Comment Period

A public notice was published electronically on October 14, 2019 on the Iowa Medicaid Enterprise (IME) website at: http://dhs.iowa.gov/ime/about/initiatives/HCBS. Public notice in a non-electronic format was done by publishing a notice in the Iowa Medicaid Enterprise member services publication sent to all Medicaid recipients. This publication was sent on October 14, 2019. Notice was sent to the federally-recognized tribes on October 14, 2019.

The final statewide transition plan was posted on the (IME) website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The transition plan will be available at that location on October 14, 2019 and comments will be received through November 14, 2019. The transition plan was available for non-electronic viewing in all of the 99 DHS county offices across the state for persons who may not have internet access. Comments will be received at the local DHS offices from October 14, 2019 through November 14, 2019.

Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The public notice provided the address for written comments to be submitted to the IME by mail or by delivering them directly to the IME office.

Summary of public Comments Received to be completed after the open public and tribal comment period:

The IME received comments from XX individuals or entities during the open comment period including members, family, advocacy organizations, provider associations, case managers and providers.

The majority of questions and comments received focused on: (list summary of comments received here and any changes to the plan based on comments)

VII. Iowa's Systemic Assessment Process

The IME has taken a multifaceted approach to the identification, review, assessment and evaluate all residential and non-residential settings where HCBS and Habilitation services are provided for the purpose of assuring all settings meet state and federal rules and regulations. This approach includes:

- Annual Provider self-assessment (form #470-4547)
- Use of Geo-mapping to identify:
  - all facilities in the state, by county (ICF/ID, nursing homes, IMD, State Resource Centers, residential care facilities and Assisted Living)
  - Identification of all provider owned and controlled homes
  - settings that may require a heightened scrutiny review
  - A review of the geo-mapping information by the Regional HCBS Specialist to identify setting within their region
- On-site residential assessments completed by community-based case managers;
- On-site review of all non-residential settings by the HCBS Quality Improvement Oversight (QIO) Unit
- Administrative rules review and changes
- Use of Iowa Participant Experience Survey (IPES) results for member experiences.

Provider Self-Assessment

The IME maintains a contract for the HCBS Quality Improvement Oversight (QIO) Unit function through a request for proposal process. The HCBS QIO Unit is the single entity that is responsible for all quality oversight activities for the HCBS and Habilitation programs, including the review and assessment of HCBS settings. While there are multiple entities responsible for gathering HCBS settings information and data, such as community based case managers and Managed Care Organizations (MCO), the HCBS QIO Unit is responsible for coordinating quality assurance activities and reporting to the IME. Currently the IME contracts with Telligen, Inc. to conduct the quality oversight activities of the HCBS and Habilitation programs.

The HCBS QIO Unit uses the HCBS Provider Self-Assessment (SA) tool (attachment A) as the foundation for all quality assurance activities. The Provider SA is an annual attestation tool completed by all HCBS Medicaid waiver providers required to be in compliance with the settings rules. Section III. Policies and Procedures, Requirement B. of the SA, was last updated in September 2018 to include the CMS settings final rule indicators. Providers are required to attest (yes or no) to each of the setting indicators on the SA and are required to have documentation to support that organizational systems are in place to support the indicators. Each provider SA is reviewed by the regional HCBS QIO Specialist assigned to work with the provider. The Specialist works with each individual provider to assure they have the quality framework needed and can attest to compliance with all the settings indicators.

The provider's approved SA is used by the HCBS QIO Unit to conduct provider service reviews and quality oversight activities. The HCBS Provider SA is incorporated into the four quality oversight review processes conducted by the HCBS QIO Unit; periodic, focused, targeted and certification reviews.

Periodic Reviews: All providers are reviewed once in a five-year cycle. During the review process providers reviewed are held accountable for responses from the self-assessment, Iowa Administrative Code, Iowa Code, and Code of Federal Regulations.

Focused Reviews: Providers are randomly selected each year to participate in a focused review. The focused review subject is determined annually and based on historical data and the IME need. The SFY '18 and '19 focus topic is HCBS setting readiness and compliance.

Targeted Reviews: A targeted review result from a complaint. A targeted review may be completed as a desk review or an onsite review.

Certification Reviews: Certification reviews occur 270 days after initial enrollment of a HCBS certified provider. Subsequent certification reviews determine the level of certification the provider. Providers can be recertified for up to a maximum of three years.

A quality oversight process of discovery, remediation and improvement is used to assure compliance with the Provider SA and all rules of the HCBS and Habilitation programs. When a compliance issue is identified through any of the four review processes, the provider is required to develop a corrective action plan (CAP) to address the issue. The CAP is submitted to the HCBS QIO Regional Specialist for review and acceptance. Once a plan is accepted, a compliance review is scheduled and conducted within 60 days to assure that the activities identified in the CAP are being implemented. Providers that demonstrate compliance with the CAP will be informed of the approval by the HCBS QIO Specialist and quality monitoring activities using the four review processes will be used for ongoing compliance. Providers unable to develop and implement an acceptable CAP to address the specific issues may have sanctions imposed. Sanctions may include probation, suspension, or termination from the Medicaid program. Any adverse action taken by the HCBS QIO Unit may be appealed by a provider.

HCBS Settings Validation Process

For validation of HCBS residential and non-residential settings, the various assessment processes and onsite reviews identified in this final STP were used as methods of discovery to identify setting compliance. The final outcome of the assessment and review process of HCBS settings is for the IME to determine whether an individual setting meets the HCBS settings rule.

Geo-mapping to identify residential and non-residential setting locations:

To assist the IME to identify HCBS residential and non-residential setting within the state of Iowa, the HCBS QIO Unit used a geo-mapping tool. Geo-mapping is a data collection tool that allows a permanent address to be entered into a database and is used to identify and map out all settings entered into the tool by county, city, and street level of detail. The HCBS QIO Unit identified and entered:

- All facilities in the state. This included the addresses of all intermediate care facilities for persons with intellectual disabilities (ICF/ID), nursing homes, institutes of mental disease (IMD), Assisted Living facilities, and state run Resource Centers and Mental Health Institutes.
- All provider owned and controlled homes as identified on the Provider Self-Assessment.
- Locations of all non-residential service settings (day habilitation, adult day Care, prevocational setting, and sheltered workshops)

The information generated from the geo-mapping tool was used to assist the HCBS QIO Regional Specialist to identify settings within their region that will require a residential or non-residential setting review and settings that may require a heightened scrutiny review based on the location of the setting. Based on the geo-mapping info, the Regional Specialist developed a provider review plan to identify and review all providers and settings within their region.

Onsite Non-Residential Review Process

As noted above, providers are required to have documentation to support the attestations identified on the annual HCBS Provider Self-Assessment regarding compliance with the settings rules. During the on-site non-residential review process, the Non-Residential Onsite Review Tool (Attachment B) is used by the HCBS QIO Specialist to review compliance with the HCBS non-residential setting indicators identified on the provider Self-Assessment and verify the provider attestations on the Self-Assessment. Each of the setting indicators on the Provider Self-Assessment is reviewed by the HCBS QIO Specialist to identify whether the indicator is included in the provider's policies and to identify the provider's evidence (documentation) that the settings indicator is being implemented according to the provider's policy and State and Federal regulations. The HCBS QIO Specialist also reviews the provider's Quality Improvement (QI) plan to assure the provider has a systemic and planned approach to monitoring and improve performance. Upon completion of the onsite review, a written report is generated by the HCBS QIO Specialist and sent the provider that identifies the findings of the review and any corrective actions that are required to come into compliance with the setting rules.

During the HCBS non-residential settings review process, if a provider is found to be out of compliance with any of the indicators, the HCBS QIO Unit works with the provider to develop a corrective action plan (CAP) to come into compliance, using the same process used to address compliance issues with the Provider Self-Assessment process identified above. Once a non-residential setting CAP is accepted, a compliance review is scheduled and conducted within 60 days to assure that the activities identified in the CAP have been implemented. Providers that demonstrate compliance with the settings rules will be informed in writing of the approval by the HCBS QIO Specialist. If the initial corrective action plan is either not accepted or the initial compliance review finds that a provider has not implemented the approved plan, the HCBS QIO Unit will continue to work with providers that are willing to work towards and are showing progress towards compliance. Providers will have until March 17, 2022 to be in full compliance with the settings rules. Once a provider is in compliance, quality monitoring activities (periodic, focused, targeted, certification reviews) are implemented for continued and ongoing settings compliance.

Onsite reviews have been completed for all HCBS providers in the state of Iowa who were enrolled to provide non-residential services (Adult Day Care, Day Habilitation, Pre-vocational and Supported Employment Services). Each reviews consisted of:

- Validation of the most recent Annual Provider Self-Assessment

- A review of policy and procedures
- An audit of member files from each service location
- A tour of all provider owned and controlled non-residential service locations.

Providers were also given an option to submit any additional material that they felt showed compliance with CMS Final Setting Rule requirements. The provider's most recent Annual Provider Quality Management Self-Assessment was reviewed prior to each onsite review. The provider's responses to each settings indicator on the Self-Assessment (yes, no, not applicable and narrative response) were reviewed to establish a baseline for the review. Providers who identified a "no" response for any requirement on the assessment was required to submit a self-identified CAP. See Provider Self-Assessment section above for the CAP process. Providers who did not complete the Annual Provider Self-Assessment within the allotted timeframe are sanctioned by the IME until the assessment is received and validated or the provider discontinues providing services. During the 2018 Annual Provider Quality Management Self-Assessment submission, no Non-Residential service providers were sanctioned.

Provider policies and procedures were submitted to the HCBS Specialist prior to the completion of the onsite setting review and were reviewed to ensure alignment with CMS Final Setting Rule and Person-Centered Planning requirements. Member files were selected randomly and reviewed onsite. If a provider had more than 40 HCBS waiver members enrolled in services, five files were reviewed. If a provider had less than 40 HCBS waiver members enrolled in services, three files were reviewed. If a provider had multiple non-residential site locations, a member from each location was selected. Member files were reviewed to ensure that contractual agreements aligned with CMS Final Setting Rule and there was evidence of Person-Centered Planning.

The HCBS QIO Specialist toured all provider owned and controlled non-residential service locations to ensure the physical setting aligned with CMS Final Setting Rule requirements. For providers who offered non-residential services in 100% integrated community settings, onsite Focused Reviews were conducted at the agency's main administrative building.

Residential Setting Assessment Process

The Home and Community Based Services (HCBS) Residential Setting Member Assessment (form 470- 5466) is used by a member's case manager or managed care community based case manager to assess a member's place of residence for compliance with the setting rules. See attachment C. The HCBS Residential Assessment form is composed of four sections: demographics, instructions, member outcomes, and final outcomes. The residential assessment form:

- Identifies who will complete a partial or full assessment. Members that live with their family, own their own home or rents a living unit from a community landlord that is not owned or operated by an HCBS service provider are presumed to live in integrated community settings and are required to complete a partial assessment. All other members are required to complete the full assessment.
- The full assessment includes nine member outcomes designed to assist with identifying the member's experience living in a community setting and using community resources.
- Requires knowledge of the member, where they live and the services received.
- Requires a conversation with the member and/or their legal representatives and provider staff, as appropriate, to determine member outcomes.

The nine member outcomes include:

1. Members Choose where and with whom they live.
2. Members choose their daily routine.
3. Members choose where they work or receive day services.
4. Members manage personal resources.
5. Members are treated with dignity and respect.
6. Members use community resources.
7. Members have access to their home and community.
8. Member exercise their rights and responsibilities.
9. Services are individualized to the needs of the member.

The nine personal outcomes are expected to be present in a member's life. Each outcome is listed separately and has a series of questions to be answered by the case manager or community based case manager (will be referred to as "case manager" throughout the remainder of this transition plan) to assist with determining how the member personally defines the outcome and whether or not the outcome is present in the life of the member. The presence of the nine outcomes identifies characteristics of living in integrated community settings. There is no right or wrong answer to the outcome questions as the outcome is defined by the member as it applies to their life in the community and identifies the experience of the member living in their residential setting.

The list of questions included on the residential assessment form are not exclusive and the case manager may ask additional questions based on the response from the member. The interview must include the member and may include others (parents, guardians, provider staff, etc.) as needed. By asking the questions, the case manager must have enough information to answer either yes or no on the final outcome question at the end of each outcome section. If the interviewer cannot make a final determination, additional guidance questions are needed. For each Yes or No response, the interviewer must provide evidence that supports the final response.

The final assessment of the member (i.e., the bottom line) asks the case manager to identify three outcomes to determine if the member has access to and uses the resources of the community in which they live to the degree desired by the member. The three outcomes include:

- The member has access and opportunity to use the community resources to meet individual needs and preferences.
- The residential setting supports the member to live, work, and recreate in the community to the degree desired by the member.
- All rights limitations that limit access to the greater community are documented in the member's person-centered plan

The HCBS Residential Setting Member Assessment is submitted to the IME by the member's case manager through the IME's OnBase system. On a monthly basis the HCBS QIO Unit pulls a data report from IMPA identifying the completed residential assessments for the past month. Members that have a "No" response to any of the above three final assessment questions are marked for follow up with the member's case manager. The IME uses the HCBS QIO complaints process (attachment F) to track the contact and follow up with the member's case manager. Initially the HCBS Regional Specialist reaches out and communicates with the case manager regarding the "no" response. If it is identified that it is a member specific limitation (i.e., rights restriction) and that the case manager has it documented in the members service plan, no further information is required. If it is identified as a

provider or service provision issue, then the “no” response will initiate a complaint. The HCBS Incident and Complaint Specialist will follow up with the case manager, the member, guardian, and provider. Depending on the information provided a corrective action plan may be required from the provider.

Provider owned and controlled setting review:

The 2018 Provider Self-Assessment (SA) Requirement B, *HCBS settings for all providers,* requires providers to self-assess and attest that they are in compliance with the settings rules. See attachment A. All provider quality oversight activities conducted by the HCBS QIO Unit use the provider response to the self-assessment during quality oversight activities with the provider.

Requirement B sections 7 – 14 of the SA applies to services in provider owned and controlled settings. A provider owned or controlled setting is defined as a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the State must ensure that the lease, residency agreement of other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.

The Provider SA is an annual attestation tool completed by HCBS Medicaid waiver providers. Section III. Policies and Procedures, Requirement B. sections 7 -14, of the SA was updated in September 2018 to include required policies and procedures for provider owned and controlled settings. Providers are required to attest (yes or no) to each of the provider owned and controlled setting indicators on the SA and are required to have documentation to support that systems are in place to support the indicator. Each provider SA is reviewed by the regional HCBS QIO Specialist assigned to the provider. For providers that indicate they are out of compliance with the provider owned or controlled setting, the HCBS Regional Specialist works with the provider to develop a CAP needed to be in compliance. Once in compliance, the HCBS Specialist uses the SA as the foundation for all future reviews of provider owned and controlled settings.

Heightened Scrutiny Review process

The federal regulation identifies certain settings that are presumed to be institutional in nature, unless it is shown through a heightened scrutiny process that the setting has the qualities of HCBS rather than those of an institution. This presumption includes any setting that is:

- Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- In a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

For the purpose of Iowa’s analysis, a facility that provides inpatient institutional treatment is defined as a facility that is statutorily excluded from providing HCBS services by the HCBS settings regulation (hospitals, nursing facilities, ICF/IDs, and IMDs).

For the definition of a public institution, Iowa relies on the sub-regulatory guidance published with the settings regulations, in which CMS discusses the definition of a public institution:

> "The term public institution is already defined in Medicaid regulations for purposes of determining the availability of Federal Financial Participation (FFP). Section 435.1010, specifies that the term public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. *Medical institutions, intermediate care facilities, child care institutions and publicly operated community residences are not included in the definition, nor does the term apply to universities, public libraries or other similar settings*." (emphasis added)

Iowa operates under the assumption that correctional facilities are also excluded from this definition.

Iowa used geo-mapping techniques to compare HCBS site locations with licensed institution locations. Because Iowa Medicaid provider information typically contains provider office locations rather than actual sites of service, the state utilized HCBS site locations obtained through the provider self-assessment and institutional data from the state survey and certification agency, the Iowa Department of Inspections and Appeals (DIA).

To explore potential settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, the state used the geo-mapping tool to compared street addresses of HCBS non-residential settings to those of licensed hospitals, ICF/IDs, and nursing facilities/skilled nursing facilities. Because Assisted Living (AL) sites may also provide HCBS, the state compared addresses of licensed AL sites of more than five beds with addresses of nursing facilities to determine if any are located in the same building.

To explore potential settings that are located in a building on the grounds of or immediately adjacent to a public institution, the state compared street addresses of HCBS sites to addresses of the two state-run ICF/ID facilities (Woodward Resource Center and Glenwood Resource Center) and the two state-run psychiatric hospitals (Cherokee Mental Health Institute and Independence Mental Health Institute), which are the only institutions in the state that fall under the public institution definition noted above.

To explore other settings that may have the effect of isolating individuals receiving Medicaid HCBS from the broader community, the state compared addresses for Residential Care Facilities (RCFs) of more than five beds with addresses for HCBS residential and non-residential sites. RCFs are not considered inpatient institutions; however, with any setting that congregates a large number of people with disabilities in one location there is increased risk that the location may have some of the qualities of an institution.

In late 2018 and early 2019, CMS provided technical guidance to all states around the heightened scrutiny criteria and review process. States must assess, identify and review all sights that will require a heightened scrutiny review and work with any setting that is presumed not to be HCBS. The review will identify all corrective actions needed to come into compliance with the final rule. Per guidance provided by CMS, providers that submit a CAP to address compliance issues and fully implement required changes before July 1, 2020 will not require a heightened scrutiny review by CMS. Providers that have not implemented required changes identified in a site specific CAP by July

1, 2020 will require Iowa to submit all providers for heightened scrutiny review for approval. Final heightened scrutiny site approval by CMS must be secured by March 17, 2022.

Relocation of Members due to non-compliance

When service locations are found to be out of compliance with the rules and the provider is unable to come into compliance through a CAP, the IME believes that most members will secure a new service provider in a location that meets the settings standards or will find alternative HCBS services in integrated settings to meet their needs. The IME has established a Member Transition Plan process to assure that all members that must transition from a non-compliant setting to a compliant setting occurs timely. The Member Transition Plan process is managed by the HCBS QIO Unit and identifies and tracks members that need to transition from a non-compliant setting to a compliant setting to assure continuity of services. The HCBS QIO Unit coordinates the member transition with the provider and the member's case manager and monitors weekly until all members are transitioned. The HCBS QIO Unit also sends weekly updates to the IME on the status of the transitions. See attachments E1 and E2 for the operational protocol for the member transition plan. A members living in any residential setting that cannot meet the HCBS Rule will be notified by of the need to relocate to another setting on or before December 31, 2021. All member transition plans must be completed no later than March 17, 2022.

Iowa Administrative Code (IAC) rules review:

The following IAC rules applicable to the 1915(c) HCBS waiver and 1915(i) Habilitation programs were reviewed for compliance with the final Settings rule.

The Iowa Administrative Code (IAC) applicable to the HCBS Waiver and Habilitation programs includes:

- CH 77 - Identifies HCBS and Habilitation provider qualifications
- CH 78 - Identifies HCBS and Habilitation service descriptions and criteria
- CH 79 - Identifies HCBS and Habilitation financial rate structure, reimbursement, and cost reporting procedures
- CH83. - Identifies HCBS and Habilitation program eligibility criteria

The analysis of the IAC rules in the initial statewide transition plan identified that as a whole, the four IAC rule chapters listed above support a HCBS member to received services in community based integrated settings. The state identified the rules support a member to have choice and control in the services and supports they receive. The state identified that the rules of the HCBS program have been periodically updated over time to reflect the addition of new services, new HCBS waiver programs and the Habilitation programs, and regulation changes at the state and federal level. As such, there are rules that require change to support full implementation of the federal setting regulations.

Iowa has a long history of providing HCBS and Habilitation supports and services to members that allows choice in where and with whom they live. Prior to July 1, 1992 when the Intellectual Disability (ID) waiver began, no residential services were offered in the existing HCBS waiver programs. All HCBS waiver services were provided in the member's home or within the greater community in which they lived. With the creation of the ID Waiver in 1992 (and later the Brain Injury (BI) Waiver) provision of residential services in provider owned and controlled settings began. At that time the state took extensive measures to assure that services were not provided in licensed environments. Residential services were provided in the member's home, family home, or in small unlicensed home

environments serving 3-4 members that were fully integrated into the local community. Supports and services were provided in the living environment where the member chose to live. Waiver service provider agreements were established, separate from lease agreements, allowing a member the freedom to move to a setting of their choice or choosing to live with different roommates knowing that their assessed service needs would be provided in any community based setting of their choice.

The rules analysis also identified the need for additional rule development regarding landlord tenant agreements in provider owned or controlled residential environments. The ID waiver is the only waiver that requires that a provider establish a contract with a member. The contract defines the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, and all room, board, and copay fees to be charged to the member and the sources of payment. The contract is separate from any lease or rental agreement that may be in place. The IAC rules do not address the need for a lease agreement between a member and the provider when the provider owns or has a vested interest in the property where the member resides. The rules analysis identified additional conflicts when services are provided in provider owned and controlled environments that require additional rule changes or modification. The first issue is lockable doors. The IAC rules for HCBS services are silent on members having lockable doors to living and sleeping units. As such, rules were promulgated in IAC 441- 77.25(5) to assure that members have the ability to lock entrance doors to their home or to their individual sleeping units with appropriate staff having access to keys to the locks as needed to assure member health and safety.

The second issue in provider owned or a controlled setting is the ability to have visitors of their choosing at any time. The current IAC rules do not limit or prevent a member from having visitors at any time of the day. As such, the ability to limit visiting times may be determined by individual provider policies and procedures or the individual decisions of provider staff working within the home. Rules were promulgated in IAC 441-77.25(5) to clarify that members may entertain visitors of their choosing at any time of the day or night.

A third issue in provider owned or controlled settings that the IAC rules remain silent involve the assurance that the residential setting is physically accessible to the members living in that environment. Rules were promulgated in IAC 441-77.25(5) to assure that all provider owned and controlled settings meet the physical accessibility needs of the members living in the setting.

The state's analysis of IAC 441- Chapter 79 rules were assessed as being silent on the HCBS settings. Chapter 79 of the IAC addresses provider rate development, rate reimbursement, and cost reporting methodologies. These rules do not have an impact the implementation of CMS settings rules. As such, they are silent on the settings in which services are provided and no change to the Chapter 79 rules are needed.

Based on the initial rules analysis, the IME developed a notice of intended action for HCBS settings regulations under ARC 3784C. The rules were written and posted for 30 days to allow for public comment and approved by the legislative rules committee. The rules were promulgated effective August 8, 2018. The attached notice of intended actions details the activities conducted to promulgate the HCBS Settings rules were taken. See attachment D for details of ARC 3784C.

Iowa Participant Experience Survey (IPES)

The IPES is a customized version of the Participant Experience Survey (PES) tools developed by CMS for use with HCBS programs. The IPES is conducted by HCBS Quality Oversight unit for the fee for services (FFS) populations and the MCOs for the members they manage unit at the IME. Contact is made with the member's case manager prior to completion of the survey, and with the member at the time of scheduling, both of which provide opportunities to alert the HCBS Specialist of any

assistance or accommodations that may be needed. The IPES interview is conducted in-person or by phone at the place and time of the member's choosing. If the member is unable to participate, a family member can be designated to respond on behalf of the member, however member participation is strongly encouraged. The HCBS Quality Improvement Oversight (QIO) Unit selects the number of interviews each year with 95 % confidence level. During fiscal year '16, 333 members were interviewed using the IPES interview tool. The charts below represent baseline data from the IPES assessment to support for HCBS settings and person centered planning.

Summary of HCBS Settings Assessment Results:

Statewide Settings Analysis by Service

Based on the state's assessment, the following services are either presumed to meet the setting regulations or the setting where the service is provided is subject to the state's assessment process. Settings designated in green in the chart below fully comply with the regulation because they are individualized services provided in the community or the recipient's private home and allow full access to the broader community according to individual needs and preferences. Services designated in yellow have been reviewed by the HCBS QIO Unit for compliance with the settings regulations.

Services by Program	AIDS/HIV	Brain Injury	Children's Mental Health	Elderly	Health & Disability	Intellectual Disability	Physical Disability	1915(i) Habilitation
Adaptive Devices			✓					
Adult Day Care								
Assistive Devices				✓				
Assisted Living								
Behavioral Programming		✓						
Case Management Services		✓		✓				✓
Chore								
Financial Management Services for Consumer Choices Option	✓	✓		✓	✓	✓	✓	
CDAC	✓	✓		✓	✓	✓	✓	
Counseling	✓				✓			
Day Habilitation								
Emergency Response		✓		✓	✓	✓	✓	
Environmental Modifications			✓					
Family and Community Support			✓					
Family Counseling & Training		✓						
Home-Based Habilitation								
Home Delivered Meals	✓			✓	✓			
Home Health Aide	✓			✓	✓	✓		
Homemaker	✓			✓	✓			

Home/Vehicle Modifications		✓		✓	✓	✓	✓	
In-home Family Therapy			✓					
Interim Medical Monitoring & Treatment								
Mental Health Outreach								
Nursing	✓			✓	✓	✓		
Nutritional Counseling				✓	✓			
Prevocational Services								
Respite	✓	✓	✓	✓	✓	✓		
Senior Companion				✓				
Supported Community Living								
Specialized Medical Equipment		✓					✓	
Residential-Based Supported Community Living (for children)								
Supported Employment		✓				✓		✓
Therapeutic Resources			✓					
Transportation		✓		✓		✓	✓	

Key:

	Settings where the service is provided are subject to the setting assessment process.
✓	Service is provided only in compliant community settings, and is not subject to the assessment process
	Service is not applicable for this HCBS program

The HCBS QIO Unit conducted its initial fact-findings reviews during FY ’17 & ‘18. During that time, the HCBS QIO Unit conducted 115 Non-Residential Provider Reviews. A total of 235 individual non-residential sites were reviewed as many providers provide non-residential services in multiple settings. The Non-Residential review tool used (Attachment B) was incorporated into the Certification, Focused and Periodic Review process.

<u>FY17 and FY18 Non-Residential Reviews</u>

Onsite Review Process

Onsite reviews were completed for all HCBS providers in the state of Iowa who are enrolled to provide non-residential services (Adult Day Care, Day Habilitation, Pre-vocational and Supported Employment Services). Reviews consisted of a validation of the most recent Annual Provider Self-Assessment, a policy and procedure review, an audit of member files from each service location, and a tour of all provider owned and controlled service locations. Providers were also given an option to submit any additional material that they felt showed compliance with CMS Final Setting Rule requirements. The Annual Provider Quality Management Self-Assessment was reviewed prior to each onsite review. The most recent 2018 Annual Provider Quality Management Self-Assessment can found in Attachment A. The agency’s response of “yes”, “no”, “not applicable” and narrative

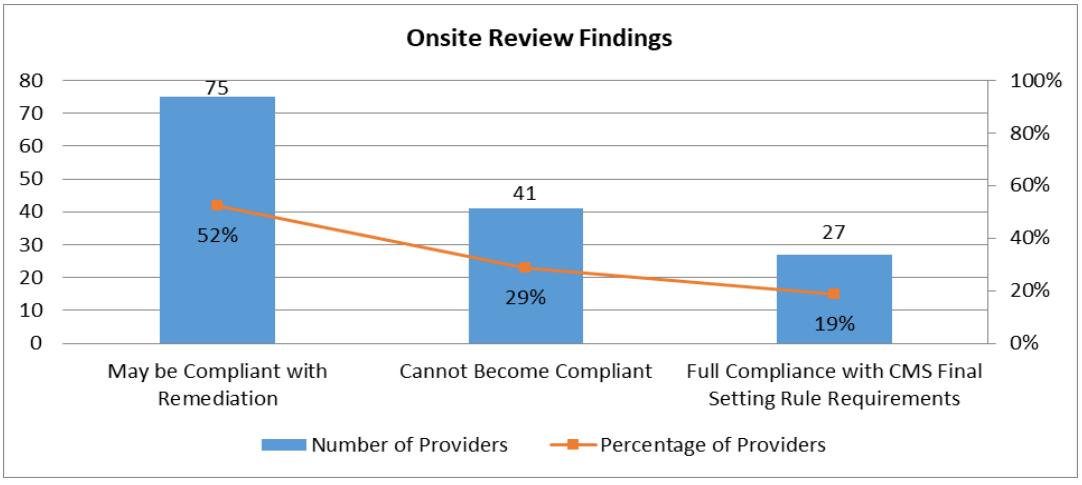
responses were reviewed to establish a baseline for the on-site review. Providers who identified a "no" response for any requirement on the assessment was required to submit a self-identified Corrective Action Plan (CAP). Any providers who does not complete the Annual Provider Self-Assessment within the allotted timeframe is placed on a sanction by the IME until the assessment is received and validated or the provider discontinues providing services. During the 2018 Annual Provider Quality Management Self-Assessment submission, no Non-Residential service providers were sanctioned.

Policies and procedures were submitted prior to the completion of the onsite review and were reviewed by the HCBS QIO Unit to ensure alignment with CMS Final Setting Rule and Person-Centered Planning requirements. Member files were selected randomly. If a provider had more than 40 HCBS waiver members enrolled in services, five files were reviewed onsite. If a provider had less than 40 HCBS waiver members enrolled in services, three files were reviewed. If a provider had multiple non-residential site locations a member from each location was selected. Member files were reviewed to ensure that contractual agreements aligned with CMS Final Setting Rule and there was evidence of Person-Centered Planning. HCBS QOU toured all provider owned and controlled non-residential service locations to ensure the physical setting aligned with CMS Final Setting Rule requirements. For providers who offered non-residential services in 100% integrated community settings, onsite Focused Reviews were conducted at the agency's main administrative building.

In FY17 and FY18, 115 Non-Residential Reviews were completed as part of the HCBS QIO Unit Focused reviews process. Approximately 60% of the state's HCBS and Habilitation providers are enrolled to provide multiple non-residential services. Thus, multiple onsite tours were conducted for many providers. These settings were determined to meet CMS Final Setting Rule requirements for community integration.

Onsite Review Findings 2017 & 2018

The results of the initial fact-finding reviews from the 2014 Provider Quality Management Self-Assessment identified that there were 143 Non-Residential providers in the state of Iowa and approximately 20% of providers in the state were in full compliance with CMS Final Setting Rule Requirements. During the FY17 and FY18 onsite Non-residential Review process it was determined that 19% (n = 27) of providers were in compliance with CMS Final Setting Rule Requirement without remediation, 52% (n = 75) may be compliant with remediation, and 24% (n = 35) cannot become compliant. At this time no providers have been put forth for heightened scrutiny.

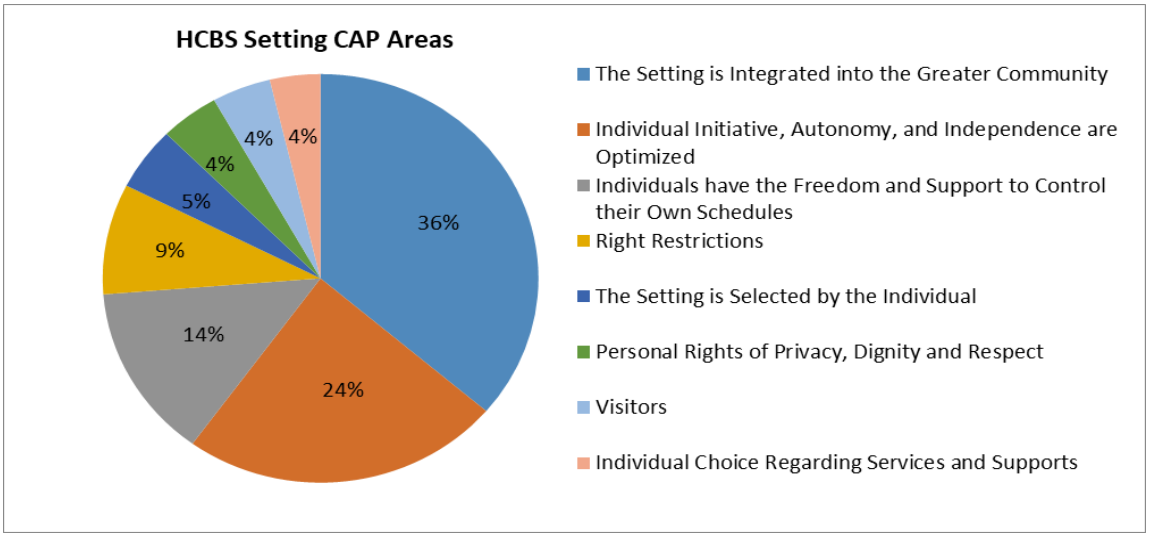


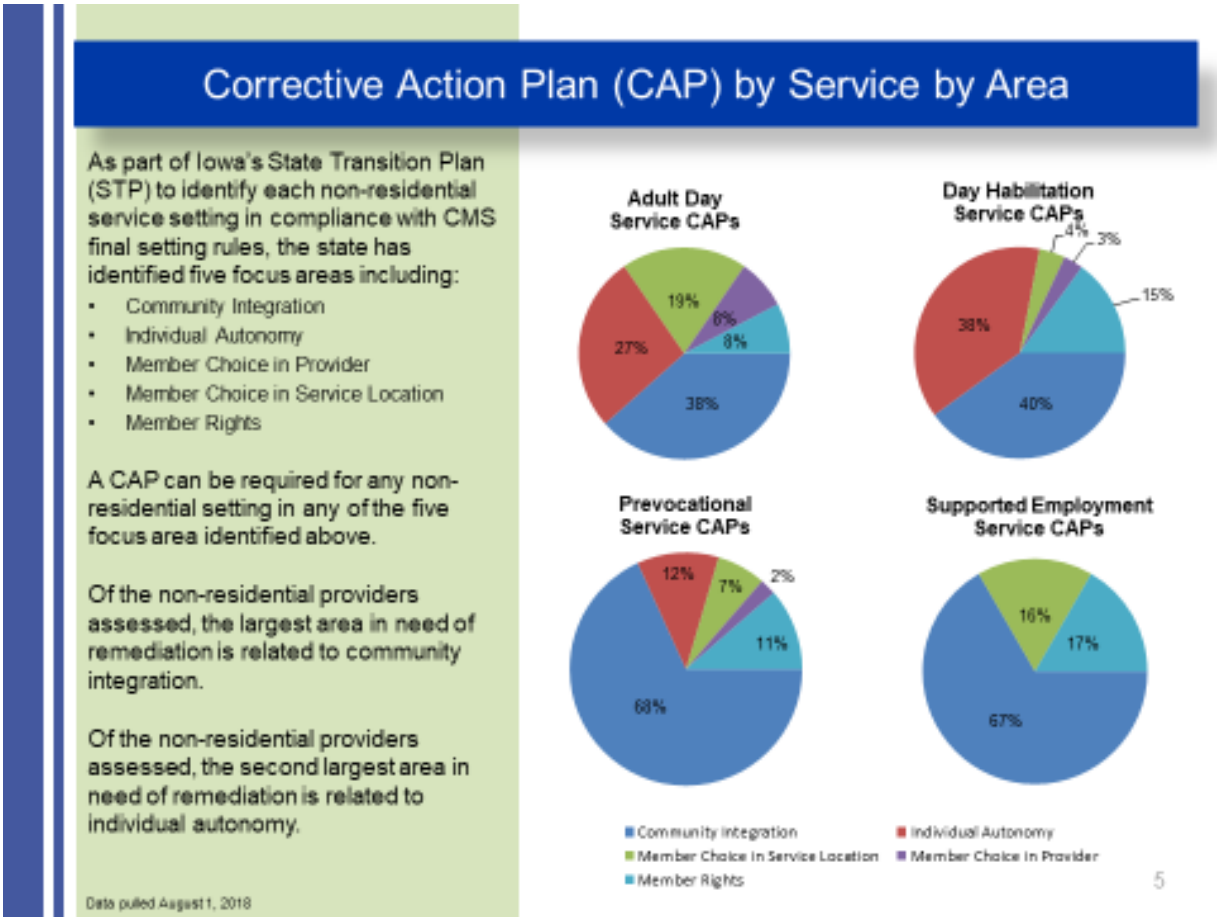
Providers who were determined to be in compliance with CMS Final Setting Rule Requirements (n=27) were not required to submit any additional follow-up material.

Providers who may be compliant with remediation (n=75) were required to submit a Corrective Action Plan (CAP) for any area that was not compliant with CMS Final Setting Rule requirements. CAPs could be required in up to 20 different areas. See Attachment B for a copy of the review tool which was incorporated into all review type tools and identifies the different CAP areas. The CMS Final Setting Rule requirements are included in three sections; HCBS Settings required for all providers, Person Centered Planning, and a Quality Improvement Plan.

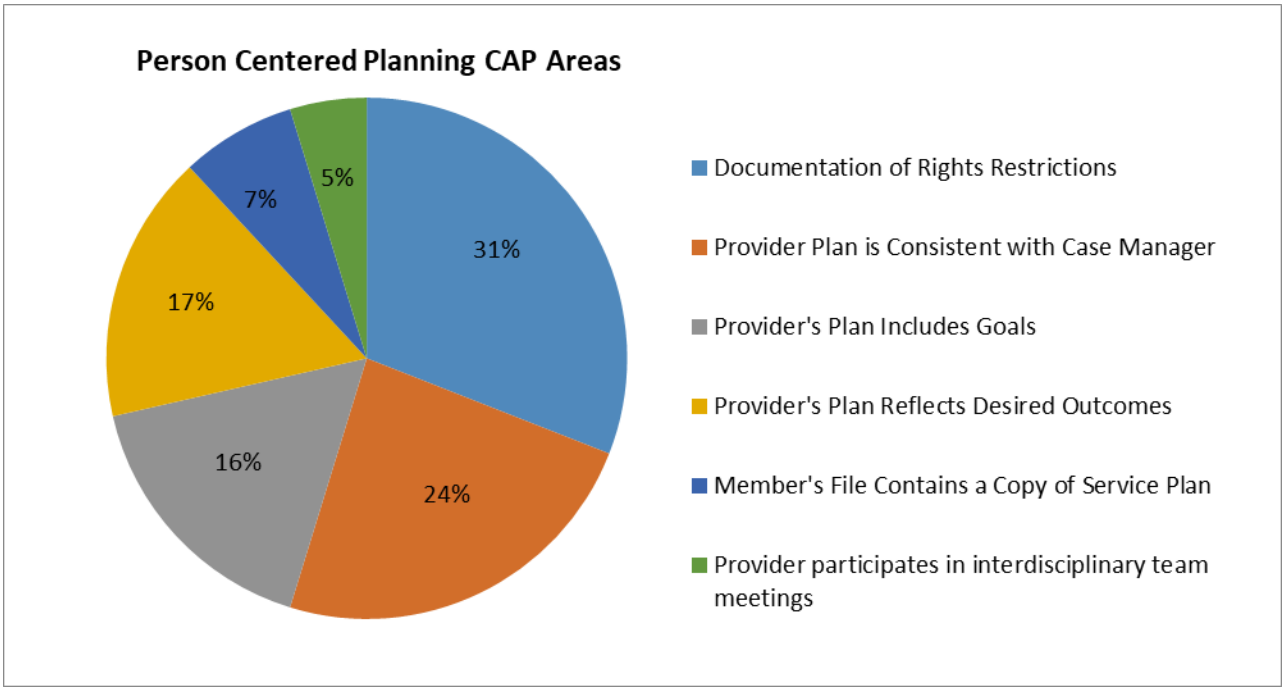
Providers who identified that they could not be compliant with CMS Final Setting Rule requirements (n=41) dis-enrolled from HCBS Non-Residential Services following the completion of the 2014 Annual Provider Quality Management Self-Assessment or in subsequent years.

In the HCBS Settings required for all providers section of the review tool 160 CAPs were required from 73 providers. The largest proportion (36%) of CAPs was required from providers in the area of community integration. The second largest proportion (24%) of CAPs was required from providers in the area of individual initiative, autonomy, and independence. The smallest proportion (7%) of CAPs was required from providers in the area of individual choice regarding services and supports. CAPs were not required in six different areas as those are applicable only to residential providers.





In the Person Center Planning section of the review tool, 42 CAPs were required from 20 providers. The largest proportion (31%) of CAPs was required from providers in the area of rights restriction documentation. The second largest proportion (24%) of CAPs was required from providers in the area of plans which reflect desired individual outcomes. The smallest proportion (5%) of CAPs was required from providers in the provider participation in interdisciplinary team meetings area.



No CAPs were required in the Quality Improvement section of the report as this section was used to provide the HCBS QIO Unit with any current plans to come into compliance with CMS Final Setting Rule requirements.

Onsite Review CAPs 2019

Providers who are required to submit a CAP have 30 days from the date of the HCBS QIO Unit report to submit a CAP for all areas in need of remediation. A CAP must include specific timelines for compliance, and identify the providers monitoring process to be used to ensure milestones and timelines are met. Due to the nature of some changes required by providers, there was no specified length of time providers must take to implement changes. Providers are required to be in full compliance with CMS Final Setting Rule Requirements on or before March 17, 2022. A CAP can be accepted, partially accepted or denied. Technical assistance was provided by the HCBS QIO Specialist for any CAP which is partially accepted or denied. During the FY17 and FY18 reviews, an accepted CAP does not indicate compliance with CMS Final Setting Rule Requirements. An accepted CAP indicates that the provider has implemented a plan for change which upon completion will be compliant with CMS Final Setting Rule Requirements. After the initial onsite Focused Review process, 75 providers were required to submit a CAP in 202 different areas.

In FY19, the HCBS QIO Unit completed a Focused desk review, onsite Certification or onsite Periodic Review for any provider who was required to submit a CAP (n = 75) during the FY17 and FY18 onsite Non-Residential Review process. These reviews used the same review tool (Attachment B) to assess compliance with CMS Final Setting Rule Requirements. All previously accepted CAPs for the FY17 and FY18 review year identified completion dates prior to the FY19 review. The HCBS QIO Unit reviewed previously submitted Annual Provider Quality Management Self-Assessment and all provider CAP material, conducted a record review of member files, examined policies and procedures for compliance with CMS Final Setting Rule requirements and reviewed any other supporting documentation submitted by the provider. If the provider was found to be non-compliant with CMS Final Setting Rule Requirements, the agency was required to submit a new or updated CAP. The CAP was reviewed by HCBS QIO Unit for acceptance. After submitting an acceptable CAP, the provider received a compliance review within 60 days of CAP acceptance. During this compliance

review, compliance was not accepted until the provider demonstrated full compliance with CMS Final Setting Rule requirements.

Onsite Review Compliance 2019

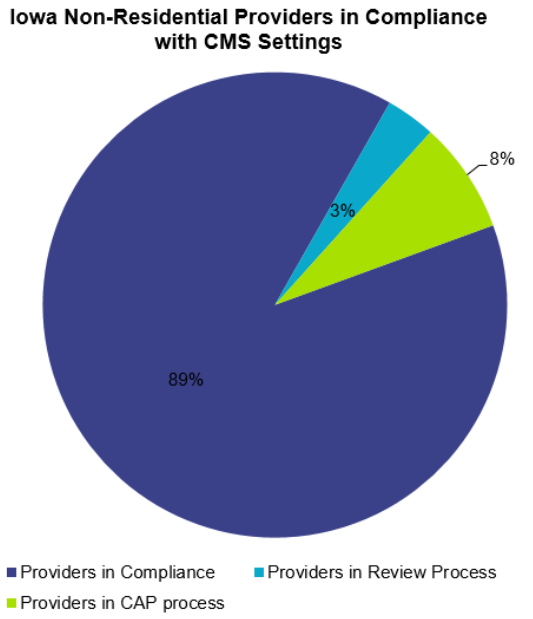
HCBS Providers in Compliance with CMS Settings

According to Iowa's STP, all non-residential providers are required to be in compliance with CMS final setting rules by March 17, 2022. Settings found to be out of compliance after March 17, 2022, may have payment withheld until compliance is demonstrated.

As of May 24, 2019, 103 (89%) providers have met compliance with CMS final setting rules. Providers in compliance with CMS final setting rules have received a final report regarding the onsite review process.

Providers in review process 4(3%) have had an onsite review but have yet to receive their final report or CAP.

Providers in the CAP process 8(8%) were not in compliance during the initial review in FY18 or FY19 and are still working on full compliance.



See Appendix A for Providers who have met compliance with CMS Final Setting Rules

Department of HUMAN SERVICES

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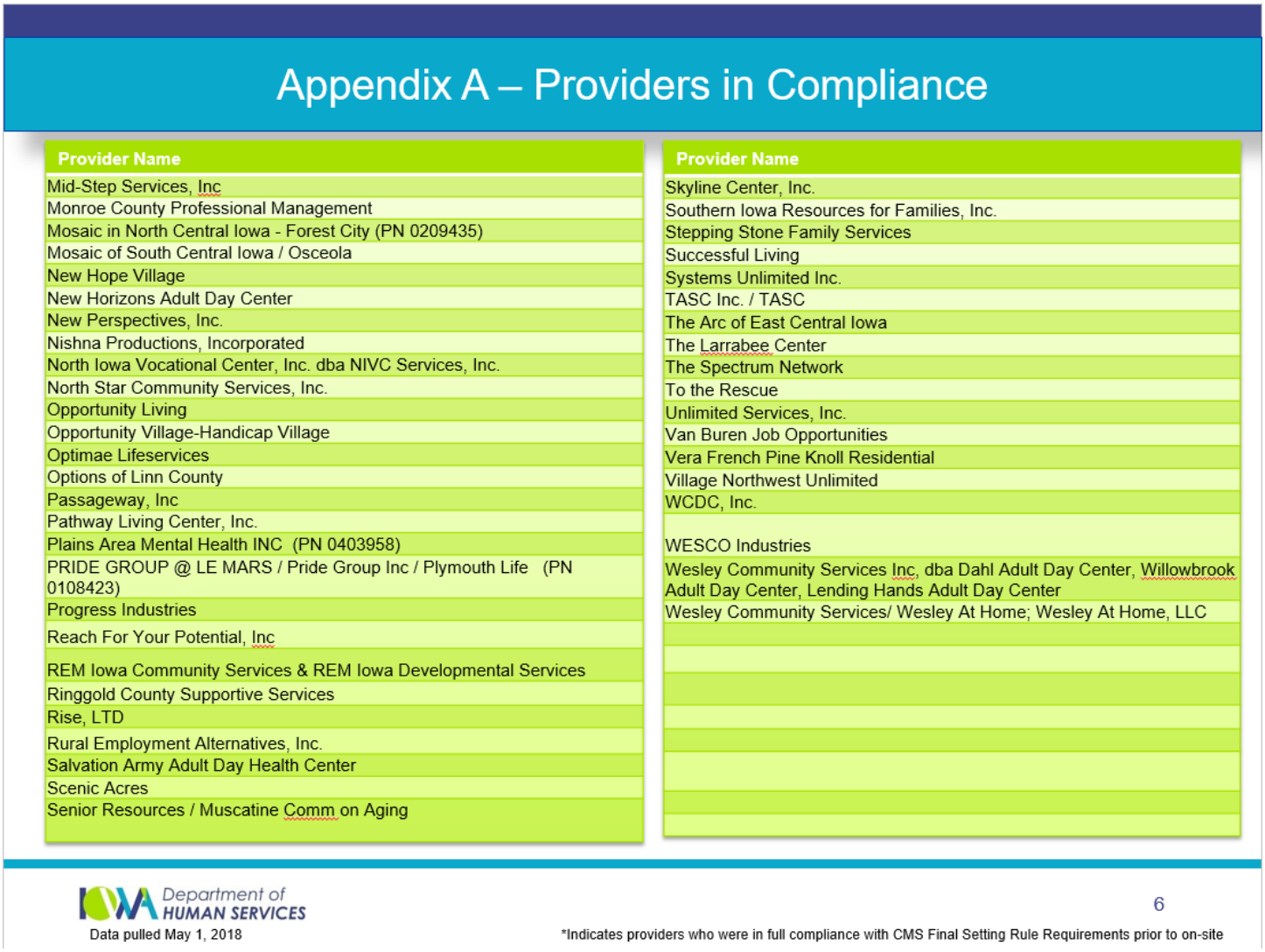
Data pulled May 23, 2019

Appendix A – Providers in Compliance

Provider Name
ABBE Center for Community Mental Health (Cedar Rapids)
Access Incorporated
Accura Healthcare of Pomeroy, LLC
Advancement Services of Jones County, Inc.
AmeriServe International, Inc.
Arc of Southeast Iowa
Area Residential Care Inc.
Beckwith Family Adult Day Services of Boone County Hospital dba Home Care Serve of Boone co Hospital
Behavioral Technologies, Corp
Bridgeview Community Mental Health Center
Cedar Valley Community Support Services
Center for Active Seniors
Centerville Community Betterment, Inc.
Central Iowa Residential Services Incorporated (CIRSI)
Choice Employment Services, LLC aka Carrie Dalhquist
Christian Opportunities Center
Community Support Advocates, LLC
Comprehensive Systems, Inc.
Cozy Corner Adult Daycare
Creative Community Options dba Candeo
Crossroads of Western Iowa
DAC, Inc./Imagine the possibilities/ Midwest Opportunities
Darrell E. Davis Adult Day Center
Easter Seals Iowa
Exceptional Opportunities, Inc.
Exceptional Persons, Inc
Everly-Ball Community Mental Health Services
First Resources Corporation

Provider Name
Friends Forever Social Education Center
Friendship Ark, Inc.
Friendship Haven
Full Circle Services Inc.
Genesis Development (Jefferson, 401 w mckinley)
Good Shepherd dba Cornerstone Assisted Living
Goodwill Industries dba Wall Street Mission (Goodwill of the Great Plains)
Goodwill Industries of Central Iowa
Goodwill Industries of Northeast Iowa, Inc.
Goodwill Industries of the Heartland
Heartland Senior Services
Hills and Dales
Homecare Options, Inc.
Homestead Living and Learning Center / The Homestead Autism Services
Hope Haven Area Development Center Corporation
Hope Haven Inc. Other services
HOPE Inc. (Honoring Opportunities for Personal Empowerment)
Horizons Unlimited of PAC Inc.
Howard Center Inc.
Ida Services, Inc.
Insight Partnership Group, LLC
Iowa Focus
Lakes Life Skills
Life Skills Training Center, Inc.
LifeWorks Community Services / Iowa Central Industries
Link Associates
Mainstream Living, Inc.
Mayor's Youth Empowerment Program (MYEP)
Mediapolis Care Facility
Mid-Iowa Workshops Inc (MIW INC.)



Appendix A – Providers in Compliance

Provider Name
Mid-Step Services, Inc
Monroe County Professional Management
Mosaic in North Central Iowa - Forest City (PN 0209435)
Mosaic of South Central Iowa / Osceola
New Hope Village
New Horizons Adult Day Center
New Perspectives, Inc.
Nishna Productions, Incorporated
North Iowa Vocational Center, Inc. dba NIVC Services, Inc.
North Star Community Services, Inc.
Opportunity Living
Opportunity Village-Handicap Village
Optimae Lifeservices
Options of Linn County
Passageway, Inc
Pathway Living Center, Inc.
Plains Area Mental Health INC (PN 0403958)
PRIDE GROUP @ LE MARS / Pride Group Inc / Plymouth Life (PN 0108423)
Progress Industries
Reach For Your Potential, Inc
REM Iowa Community Services & REM Iowa Developmental Services
Ringgold County Supportive Services
Rise, LTD
Rural Employment Alternatives, Inc.
Salvation Army Adult Day Health Center
Scenic Acres
Senior Resources / Muscatine Comm on Aging

Provider Name
Skyline Center, Inc.
Southern Iowa Resources for Families, Inc.
Stepping Stone Family Services
Successful Living
Systems Unlimited Inc.
TASC Inc. / TASC
The Arc of East Central Iowa
The Larrabee Center
The Spectrum Network
To the Rescue
Unlimited Services, Inc.
Van Buren Job Opportunities
Vera French Pine Knoll Residential
Village Northwest Unlimited
WCDC, Inc.
WESCO Industries
Wesley Community Services Inc, dba Dahl Adult Day Center, Willowbrook Adult Day Center, Lending Hands Adult Day Center
Wesley Community Services/ Wesley At Home; Wesley At Home, LLC

On-going Monitoring of Non-Residential Settings

FY20 and Subsequent Years Non-Residential Reviews:

Beginning in FY20, Non-Residential service providers will be monitored at a minimum on a 5 year cycle or more frequently as required by the provider's certification review and the HCBS QIO quality oversight process. All tools used during the FY17, FY18, and FY19 Non-Residential review process will continued to be utilized to assess compliance.

In addition to the continued onsite review process, all providers will continue to submit an Annual Provider Quality Self-Assessment. Any providers that indicates a "no" response are required to submit a self-identified CAP to address the issue and must follow the CAP process noted above. The submission of the self-assessment is required for certain provider types to maintain enrollment as an Iowa Medicaid provider. The provider types can be found on the Provider Quality Self-Assessment in Section B. The assessment must be completed and submitted to the HCBS QIO Unit by December 31st of each year.

Following the completion of the Provider Quality Self-Assessment, the HCBS QIO Unit will qualitatively validate each provider's response. The HCBS QIO Unit will review old self-assessments responses and CAPs to identify if there are any changes that have occurred since the agency's last onsite review. The HCBS QIO Unit will also verify service enrollment and discuss selected responses with providers that may not align with the findings of the qualitative review. When providers are selected for an onsite review every five years or as their certification permits, onsite validation of the Annual Provider Quality Management Self-Assessment will be conducted by the HCBS QIO Unit. During each review, providers are instructed that responses from their most recent Self-Assessment are used to drive the review.

Any provider who does not submit the Annual Provider Quality Management Self-Assessment within the allotted time is referred to the IME for review. Providers are evaluated by the IME for sanctions.

Since the implementation of CMS Final Setting Rule requirements several changes have been made to the assessment. In 2015, the assessment was modified to include all CMS Final Setting Rule Requirements in Section B. In 2017, Section D was added. The section identifies that providers are required to submit an update on compliance with CMS Final Rule Setting if a CAP was self-identified at any time or identified during any review during the previous year.

New Providers

New providers are required to submit an application to the HCBS QIO Unit and a Self-Assessment prior to enrollment as a HCBS provider with the Iowa Medicaid Enterprise (IME). The HCBS QIO Unit evaluates all applications and self-assessments to ensure compliance with CMS Final Setting Rule requirements. The new provider will have an onsite review conducted within 270 days of beginning service provision. At this time, the HCBS QIO Unit will follow the review process outlined above to validate responses of the self-assessment and ensure compliance with Iowa Code, Iowa Administrative Code and Code of Federal Regulations.

Heightened Scrutiny Reviews

Thirteen providers have been identified through the geo-mapping process and HCBS QIO Unit personnel review of providers in Iowa that provide HCBS and Habilitation services. The HCBS QIO Unit has categorized each setting:

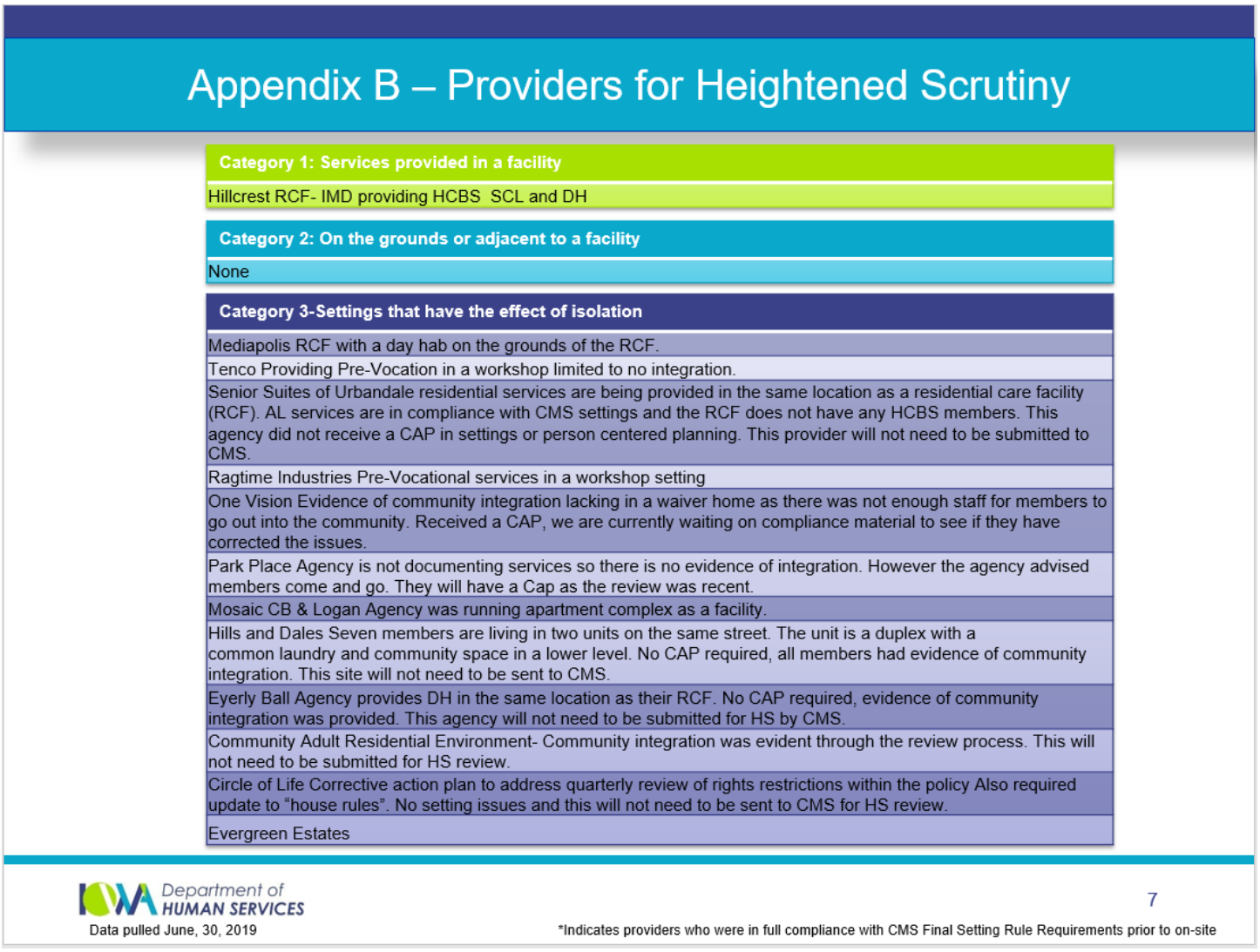
- Category 1 - HCBS services being provided in a facility
- Category 2 - HCBS services are being provided on the grounds of or adjacent to a facility
- Category 3 - HCBS services are provided in a setting that has the effect of isolation

No category 1 providers have been identified by the HCBS QIO Unit.

One category 2 provider has been identified and will end services in the location as they have not been able to develop a CAP to come into compliance way to make the setting compliant.

Twelve category 3 agencies have been identified by the HCBS QIO Unit. All providers have submitted CAP and the HCBS QIO Unit identifies that all locations should come into full compliance prior to the due date for Heightened Scrutiny packet prior to July 1, 2020. Per CMS guidance, providers that are in full compliance with the HCBS Settings rule by July 1, 2020, will not be required to go through the

heightened scrutiny process. Based on the initial review and follow up CAPs, the HCBS QIO Unit and the IME do not anticipate submitting any setting for a heightened scrutiny review.



Appendix B – Providers for Heightened Scrutiny

Category 1: Services provided in a facility
Hillcrest RCF- IMD providing HCBS SCL and DH

Category 2: On the grounds or adjacent to a facility
None

Category 3-Settings that have the effect of isolation
Mediapolis RCF with a day hab on the grounds of the RCF.
Tenco Providing Pre-Vocation in a workshop limited to no integration.
Senior Suites of Urbandale residential services are being provided in the same location as a residential care facility (RCF). AL services are in compliance with CMS settings and the RCF does not have any HCBS members. This agency did not receive a CAP in settings or person centered planning. This provider will not need to be submitted to CMS.
Ragtime Industries Pre-Vocational services in a workshop setting
One Vision Evidence of community integration lacking in a waiver home as there was not enough staff for members to go out into the community. Received a CAP, we are currently waiting on compliance material to see if they have corrected the issues.
Park Place Agency is not documenting services so there is no evidence of integration. However the agency advised members come and go. They will have a Cap as the review was recent.
Mosaic CB & Logan Agency was running apartment complex as a facility.
Hills and Dales Seven members are living in two units on the same street. The unit is a duplex with a common laundry and community space in a lower level. No CAP required, all members had evidence of community integration. This site will not need to be sent to CMS.
Eyerly Ball Agency provides DH in the same location as their RCF. No CAP required, evidence of community integration was provided. This agency will not need to be submitted for HS by CMS.
Community Adult Residential Environment- Community integration was evident through the review process. This will not need to be submitted for HS review.
Circle of Life Corrective action plan to address quarterly review of rights restrictions within the policy Also required update to "house rules". No setting issues and this will not need to be sent to CMS for HS review.
Evergreen Estates

Department of HUMAN SERVICES

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Data pulled June, 30, 2019

*Indicates providers who were in full compliance with CMS Final Setting Rule Requirements prior to on-site

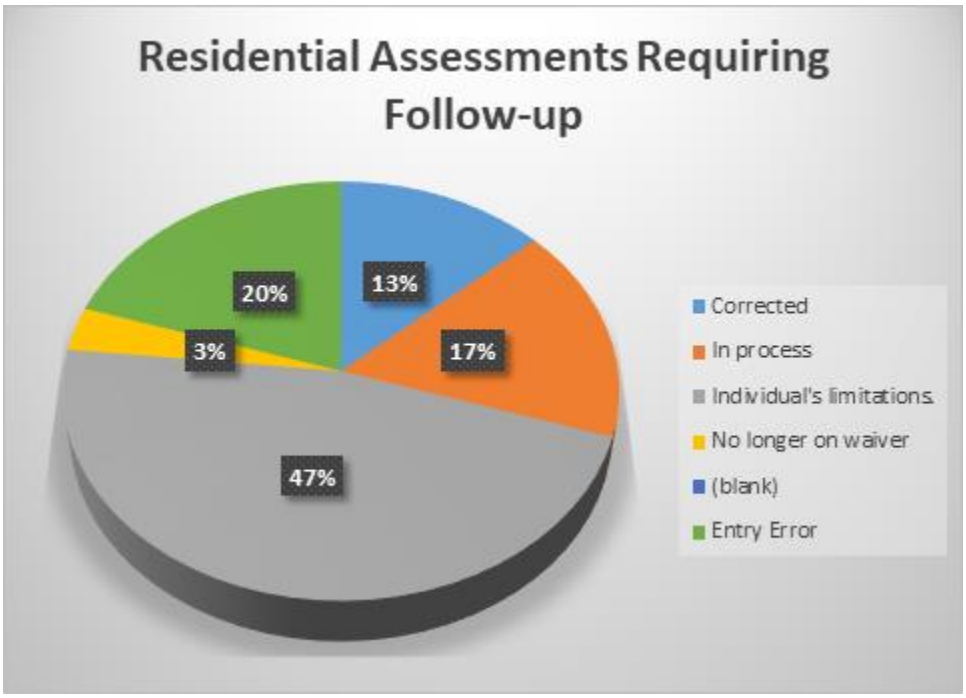
Residential assessment review

The HCBS Residential Setting Member Assessment (form 470-5466) is submitted to the IME by the member's case manager through the IME's OnBase system. On a monthly basis the HCBS QIO Unit pulls a report from IMPA identifying the completed residential assessments for the previous month. Members that have a "No" response to any of the three final assessment questions are marked for follow up with the member's case manager. Once a member is identified for follow up, the HCBS Regional Specialist reaches out and communicates with the case manager regarding the "no" response. If it is identified that the issue is a member specific limitation (i.e., rights restriction) and that the case manager has it documented in the members service plan, no further information is required. If the issue is identified as a provider or service provision issue then the "no" response will initiate a

complaint. The HCBS Incident and Complaint Specialist will follow up with the case manager (CM) or community based case manager (CBCM), the member, guardian, and provider. Depending on the information provided, a corrective action plan may be required from the provider. All follow up activity is initialed and tracked by the HCBS QIO Unit through a master HCBS Residential assessment spreadsheet. The spreadsheet identifies the member, CM or CBCM contact information, the assigned MCO, the current status of the follow up activity, and feedback and communication with the CM or CBCM. All member issues are follow through to final resolution.

During fiscal year '19, the HCBS QIO Unit identified 30 residential assessments with a "no" response to any of the final 3 questions that required follow up with the member's CM or CBCM.

Row Labels	Count of Determination
Corrected	4
Entry Error	6
In process	5
Individual's limitations.	14
No longer on waiver	1
Grand Total	**30**



The following is the description of follow up activities with the residential assessments:

- "Corrected" means the HCBS QIO Unit received a new residential assessment for the member that no longer requires follow-up.
- "Entry Error" means the HCBS QIO Unit contacted the CM or CBCM and they advised they entered "No" in error.

- "In-Process" means the HCBS QIO Unit is currently following up with the CM, CBCM, provider, or member.
- "Individual Limitation" means that the "No" response is due to a member issue and not a settings issue. In these situations the HCBS QIO Unit verifies that the individual limitations is identified in the member's person centered service plan.
- "No longer on waiver" identifies members that are no longer on waiver and not subject to the residential setting assessment process.

Beginning in FY '20, the HCBS QIO Unit will continue to aggregate and monitor the residential assessments on a monthly basis and follow up with all identified issues. A Residential Assessment report is developed by the HCBS QIO Unit and reviewed by the HCBS Quality Oversight committee on a quarterly basis.

Iowa Administrative Code Rule Changes

Below is a high level analysis of the Iowa Administrative Code (IAC) applicable to the Habilitation and HCBS Waiver programs as identified in the initial STP approved by CMS.

There are four chapters that that govern the HCBS programs:

- Chapter 77 - applies to HCBS provider qualifications
- Chapter 78 - applies to HCBS provider service delivery
- Chapter 79 - applies to HCBS provider reimbursement
- Chapter 83 - applies to HCBS member eligibility

Each chapter that applies to the HCBS and Habilitation programs was reviewed for compliance with the HCBS Settings and rule changes identified. Below in the results of the initial review.

Medicaid Administrative Rules Summary of Results	
Rule	**Result**
441—IAC—77.25: HCBS Habilitation Services Conditions of Participation for Providers	The majority of rules support; additional rule language needed to clarify CMS setting regulations
441—IAC—77.30: Health and Disability Waiver Conditions of Participation for Providers	The majority of the rules support; additional rule language needed to clarify CMS setting regulations
441—IAC—77.33: Elderly Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.34: AIDS/HIV Waiver Conditions of Participation for Providers	The majority or rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.37: Intellectual Disability Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.39: Brain Injury Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations

441—IAC—77.41: Physical Disability Waiver Conditions of Participation for Providers	Silent
441—IAC—77.46: Children's Mental Health Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.27: HCBS Habilitation Services Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.34: Health and Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.37: Elderly Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.38: AIDS/HIV Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.41: Intellectual Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.43: Brain Injury Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.46: Physical Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.52: Children's Mental Health Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—79: Other Policies Relating To Providers of Medical and Remedial Care	Silent
441—IAC—83: Medicaid Waiver Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—90: Targeted Case Management	The majority of rules supports; additional rule language needed to clarify CMS setting regulations

Based on the analysis of the rules, the IME issued a notice of intended action, ARC 3784C. See attachment D. The purpose and summary of the proposed rules are as follows:

> The Centers for Medicare and Medicaid Services (CMS) has issued regulations that define the residential and nonresidential settings in which it is permissible for states to provide and pay for Medicaid home- and community-based services (HCBS). The purpose of the CMS regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. These regulations also aim to ensure that individuals have a free choice of where they live and who provides services to them, as well as to ensure that individual rights are not restricted. While providing Medicaid HCBS in institutional settings has never been allowed, these new regulations clarify that HCBS may not be provided in settings

that have the qualities of an institution. The federal regulations were effective March 17, 2014, with an initial five-year transition time period for all HCBS providers to be in full compliance with the regulations or lose federal HCBS funding for services provided in the setting. Due to the complexity of the changes required for full compliance, CMS extended the implementation time period by three years on May 9, 2017. The State has until March 17, 2022, to demonstrate full compliance with the HCBS settings regulations. As part of a statewide transition plan developed to transition HCBS services to meet the federal regulations, CMS required the State of Iowa to complete a full assessment of the administrative rules in the Iowa Administrative Code for compliance with the federal regulations. These proposed amendments make changes to the Department's administrative rules necessary for full compliance with federal regulations as cited above.

Any interested person was able to submit written comments concerning this proposed rulemaking. The open comment period follows the state guidelines for posting proposed rules for public comment. Written comments in response to this rule making were received by the Department through 4:30 p.m. on May 29, 2018.The Department received two written comments during the open public comment period. Written comments were received from:

- Iowa Legal Aid, 1700 South 1st Avenue, Suite 10, Eastdale Plaza, Iowa City IA 52240.
- Leading Age Iowa, 11001 Aurora Ave., Urbandale Iowa, 50322

Below are the comments received and the state's response to the comments.

Comment #1 from Iowa Legal Aid:

With regards to the proposed new subrule 77.25(5), Iowa Legal Aid submits the following comment.

1) The proposed changes are based on 42 CFR Section 441.301(c) and 42 CFR Section 441.710. Those sections both require the following conditions be met in any HCBS setting that is a provider-owned or controlled residential setting:

> The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the State must ensure that the lease, residency agreement of other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

This language is not reflected in DHS' proposed regulations. These protections are important to individuals receiving HCBS waiver services in provider-owned or controlled residential settings, because these settings do not afford protections against involuntary discharge in the way that nursing homes do, for example. We request that the language and concepts from these CFR regulations with regard to protections against eviction be reflected in the proposed regulation.

State Response:

The State agrees with the comment. Based on the comment the following rule will be amended in ARC 3784C and become part of the final rule change:

Item 2. Adopt the following **new** definition of "Provider-owned or controlled setting" in subrule

77.25(1):

"Provider-owned or controlled setting" means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided or the financial conditions applicable to tenants. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the State must ensure that the lease, residency agreement of other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Comment #2 from Leading Age Iowa:

Leading Age Iowa (LAI) has identified issues with the "HCBS settings rule":

- LAI does not take issue with the intent of the rule.
- Implementation of the settings rule forbids HCBS settings from being institutional in nature or located in the same building, on the grounds of, or adjacent to entities that are institutional in nature like nursing facilities and hospitals.
- LAI fears that the HCBS settings rule may restrict, instead of expand, certain HCBS programs.
- The settings rule may have impact on elderly waiver recipient's ability to receive services.
- Purchase on new building or buying a new location for services to meet the settings rule is prohibitive.

LAI asks that further guidance be put into ARC 3784C to give providers more clarity in the site specific review process.

State response:

The Centers for Medicare and Medicaid Services (CMS) states the intent of the HCBS settings rule is to assure that members accessing HCBS services are receiving those services in integrated community settings and not in institutional settings or settings presumed to be institutional in nature. Settings that are presumed to be institutional are not prohibited from providing HCBS services, but must take additional steps to assure that the settings meet the intent of the settings rules.

The state believes that the HCBS setting rules in ARC 3784C give all residential and non-residential providers the criteria needed for compliance with the HCBS settings. Due to the diversity of settings where services from each of the seven HCBS waivers and state plan Habilitation services are

provided in the state, the Iowa Administrative Code rules cannot detail the specifics needed for compliance in individual provider settings.
All settings where residential and non-residential services are provided require oversight by the HCBS Quality Improvement Oversight (QIO) Unit. The HCBS QIO Unit uses the Provider Self-Assessment as the foundation of HCBS settings compliance. The Self-Assessment is used by a provider and the assigned HCBS Specialist to look at the provider specific setting(s) and review for compliance with the rules. The HCBS Specialist works with the provider on compliance within individual settings and is available to provide technical assistance as needed.

As such, the state will not make any changes to the HCBS Setting rules based on LAI comments and will continue to use the HCBS Self-Assessment and Quality Oversight review process to work with providers on individual setting compliance issues.

The Settings rules identified in ARC 3784C and changes made through the public comment process were effective August 8, 2018.

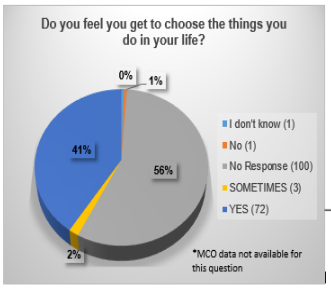
Ongoing Public and Provider Communication:

The state has undertaken various activities to assist the public and providers in understanding the federal settings regulations since the earliest draft of the transition plan. These activities have included:

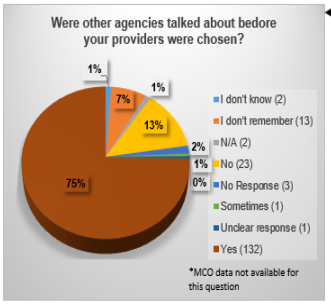
- A webpage dedicated to the statewide transition plan was published on the IME website (http://dhs.iowa.gov/ime/about/initiatives/HCBS), which includes links to information from outside sources such as CMS, the National Senior Citizen's Law Center, and HCBSAdvocacy.org
- A STP stakeholder committee has been developed for input and feedback into the STP. The committee is made up of members/families, providers, case managers, Disability Rights Iowa, and advocacy organizations
- Iowa Participant Experience Survey (IPES pertain ask members questions centering on individual initiative, autonomy, and independence in making life choices.

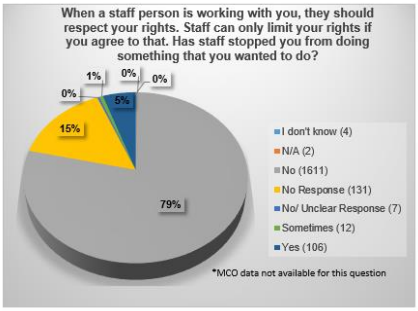
Iowa Personal Experience Survey (IPES)

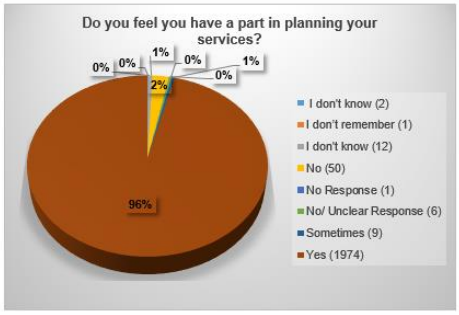
The following IPES results from Fiscal Year '19 pertain to questions centering on individual initiative, autonomy, and independence in making life choices. The HCBS QIO Unit completed 156 IPES surveys for the fee-for-service population and had 15 flags requiring case manager follow up.

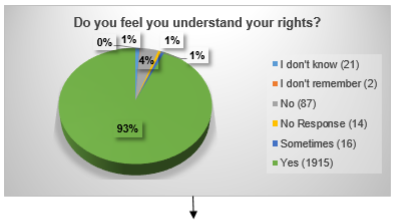


Members responding "No" or "Sometimes" were asked this follow up question:

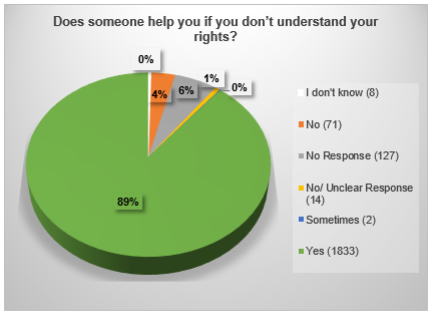


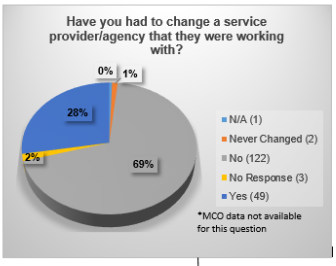




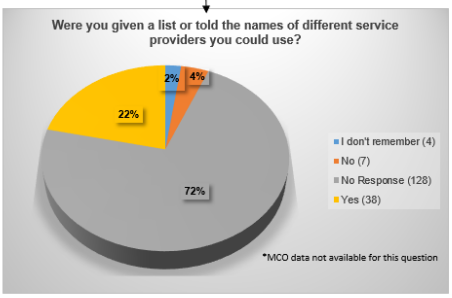


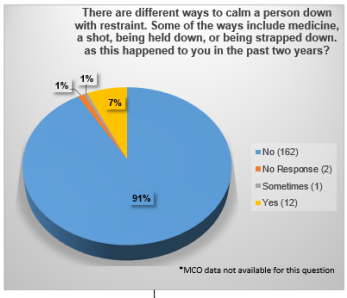
Members responding anything other than "Yes" were asked this follow up question:



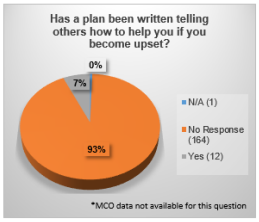


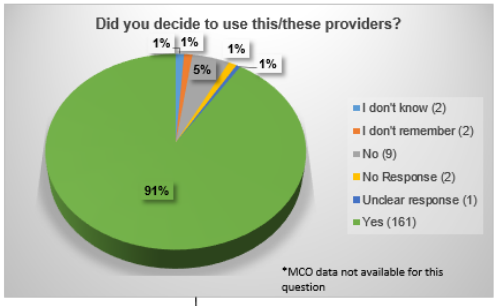
Members responding "Yes" or "I don't remember" were asked this follow up question:



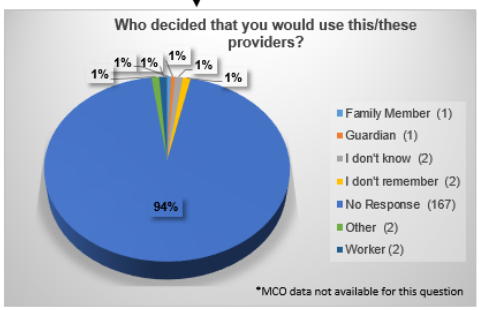


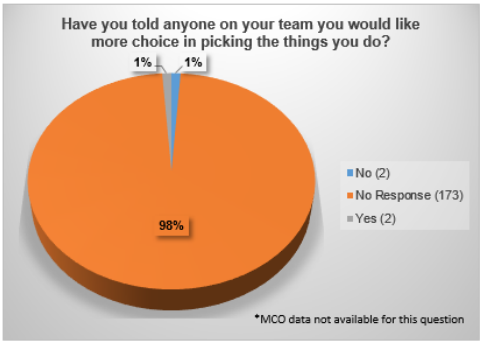
Members responding "Yes" were asked these follow-up questions:





Members responding "No" were asked this follow-up question:





The 2019 IPES results indicate that the majority of members receiving HCBS feel that they have choice in the direction of their lives and in the services and providers they use. Results also indicate that a large majority of members feel that they know their rights and that their rights are respected. The IPES is constructed such that for certain items where a member's response indicates a negative impact for the member, the response is flagged for follow-up by the member's case manager.

The state will continue to use IPES results on an individual member basis, combined with results from other assessment activities as described in the final statewide transition plan, to ensure compliance with the regulations. The information will be gathered by the HCBS QIO Unit monthly and incorporated into the HCBS QIO quarterly QA report and reviewed by the IME Quality Oversight committee on a quarterly basis.

Ongoing Monitoring of Residential and Non-Residential Settings

Iowa's approach for the monitoring of settings compliance prior to and after the March 17, 2022, deadline capitalizes on our existing quality assurance processes as described in this final Statewide Transition plan. This includes the use of:

- The Provider Self-Assessment. This tool will be the will continue to be submitted to the HCBS QIO Unit annually to assure providers attest to being in compliance with the HCBS Settings rules. The SA will be used to assess that providers are providing services in integrated community based settings. At a minimum, all providers will have an on-site review every 3 – 5 years to assess compliance with the settings. Providers may also be reviewed for compliance as part of a focused review of services or through a complaint received by the HCS QIO Unit.
- On-site Residential Assessments. The HCBS Residential Setting Member Assessment will continue to be completed on an annual basis by a member's case managers and community-based case managers. The HCBS QIO Unit will gather member residential assessment information monthly and report to the IME quarterly on the findings of the assessment.
- On-Site Non-Residential Settings Review. Non-residential reviews will be part of the on-site Provider Self-Assessment review process by the HCBS Quality Improvement Oversight (QIO) Unit. See first bullet point above.
- Administrative rules review and changes. When rules changes are identified through the Quality Assurance review process, proposed rules will go through the Administrative Rules Review process as identified in IAC
- Use of Iowa Participant Experience Survey (IPES). The HCBS QIO Unit will gather member IPES information monthly and report to the IME Quality Oversight committee quarterly on the findings of the assessment.

The HCBS QIO Unit will utilize an ongoing process of discovery, remediation, and improvement strategies to identify residential and non-residential setting issues and work with the member, their case manager, and service providers to assure ongoing compliance with the HCBS setting guidelines. The HCBS QIO Unit quality assurance processes, including the annual provider self-assessment, onsite assessment, compliance reviews and remediation activities, will continue to ensure that all HCBS settings will continue to meet the requirements on an ongoing basis. Settings found to be out of compliance after March 17, 2022, will be terminated for all services rendered in the setting until compliance with the settings rules is demonstrated and confirmed by the HCBS QIO Unit.

The Iowa Medicaid Enterprise is the state entity responsible for the monitoring and oversight of all HCBS Waiver and Habilitation Program services. The IME has worked diligently to develop and implement various quality assurance oversight activities conducted by the HCBS QIO Unit to

regularly assess and review all residential and non-residential settings. Though these various quality oversight activities described in this final STP document, the IME believes they have established methods of collecting discovery information that will allow them to evaluate the current status of the HCBS Settings rules. Upon discovery, the IME will identify settings meet the Final Settings rules and have systems in place to remediate setting found to be out of compliance and to work with members, case managers or community based case manager, and providers to develop corrective action plans to come back into compliance

Attachment A- Provider Self- Assessment

Home- and Community-Based Services (HCBS)
2018 Provider Quality Management Self-Assessment

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health and Disability Waiver (HD)
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

Each provider is required to submit one, six-section self-assessment by **December 1, 2018**. This form is to be completed and submitted via fillable PDF as directed on the Provider Quality Management Self-Assessment[1] webpage. A password-protected electronic signature is required in Section E. in order for this document to be accepted. **Incomplete self- assessments will not be accepted.**

Section A. Identify the agency submitting this form.

Section B. Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services via email imeproviderservices@dhs.state.ia.us or phone at 800-338-7909, option 2.

Section C. Select the response option from the "Response Option" column that indicates the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the agency and must be resubmitted.

- Response options Include:
  - Yes or No response are available if required for the service
  - Yes, No, and N/A responses are available when the standard is not required for all service providers

    *Note: All standards are considered best practices

Section D. Please fill out the information as requested

Section E. Please complete and sign as directed

Section F. Please fill out the information as requested.

Questions should be directed to the HCBS Specialist assigned to the county where the parent agency is located. For a complete list of HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please go to the DHS webpage HCBS Waiver Provider Contacts[2]

[1] https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts

Section A. Agency Identification

Click for help

Please identify your parent agency by providing the following information using the text entry fields below.

Employer ID Number (EIN) (9 digits):					
Associated NPI:					
Agency Name (as registered to EIN):					
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Executive Director/Administrator:			Title:		
Email:			Telephone:		
Self-Assessment Contact Person:			Title:		
Email:			Telephone:		
Agency Website Address:					

Identify below any affiliated agencies covered under this self-assessment.

Agency Name	City	County	Associated NPI (10 digits)

Section B. Service Enrollment

Click for help

Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the annual Provider Quality Management Self-Assessment. If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

Program	AIDS/HIV Waiver	BI Waiver
Services	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Counseling ☐ Respite	☐ Adult Day Care ☐ Behavior Programming ☐ Agency Consumer-Directed Attendant Care ☐ Family Counseling and Training ☐ Interim Medical Monitoring and Treatment ☐ Prevocational Services ☐ Respite ☐ Supported Community Living ☐ Supported Employment
Program	**CMH Waiver**	**Elderly Waiver**
Service	☐ Family and Community Support Services ☐ In-home Family Therapy ☐ Respite	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Assisted Living Service ☐ Case Management ☐ Mental Health Outreach ☐ Respite

Program	HD Waiver	ID Waiver
Services	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Counseling ☐ Interim Medical Monitoring and Treatment ☐ Respite	☐ Adult Day Care ☐ Agency Consumer Directed Attendant Care ☐ Day Habilitation ☐ Interim Medical Monitoring and Treatment ☐ Prevocational Services ☐ Residential-Based Supported Community Living ☐ Respite ☐ Supported Community Living ☐ Supported Employment
Program	**PD Waiver**	**Habilitation Services**
Services	☐ Agency Consumer Directed Attendant Care	☐ Day Habilitation ☐ Home-based habilitation ☐ Prevocational Habilitation ☐ Supported Employment Habilitation

Section C. State and Federal Standards

Click for help

For each of the following standards, the agency must select a response from each dropdown menu.

- Indicating "**Yes**" means the agency currently has in place policies and/or practices meeting the proposed standards and can provide documented evidence verifying such.
- Indicating "**No**" means the agency does not currently have policies, practices, and documented evidence in place. When a "**No**" is indicated, the agency must document in the space provided at the end of each area or requirement plans to meet the standards. The plan must identify the agency's timeline for meeting the standards. **Implementation of corrective action to address current Code of Federal Regulations (CFR), Iowa Code, or Iowa Administrative Code (IAC) standards must be completed within 30 days of the date in Section F of this form.**
- The selection of **"NA"** indicates the item is not applicable to the programs and services your agency is enrolled for, and is not applicable in accordance to Centers for Medicare and Medicaid, Code of Federal Regulations, Iowa Code, or IAC.

This annual Provider Quality Management Self-Assessment will be returned to the agency if all sections are not completed, responses chosen are not compliant with CFR, Iowa Code, or IAC, or otherwise deemed unacceptable.

If the agency requires technical assistance, contact the regional HCBS Specialist assigned to the agency
(see page one).

I. Fiscal Accountability

IAC Chapters 78 and 79

At a Minimum, all providers will maintain evidence of:	
1. A system for setting rates based on reasonable and proper costs of service provision (for example: D-4s, fee schedules, County Rate Information System CRIS Report, Documentation to support assigned tier rate)	Yes
2. The maintenance of fiscal and clinical records for a minimum of five years	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

II. Training Requirements

IC 235B.16, 232.69 and IAC Chapter 77

Trainings are required for certain habilitation and waiver programs as listed below. It is recommended as a best practice that each waiver program provide all the trainings listed below.

1. The curriculum used by the provider is approved by the Iowa Department of Public Health, and includes the following:	
a. Child and/or dependent abuse training completed within six months of hire (or documentation of current status)	Yes
b. Training every five years	Yes
2. Member rights	Yes
3. Rights restrictions and limitations	Yes
4. Member confidentiality	Yes
5. Provision of member medication	Yes
6. Individual member support needs, including Behavior Intervention Plans (BIP) when applicable	Yes
7. Incident reporting	Yes
8. Brain injury training completed within 60 days of beginning service provision	Yes
9. CMH Waiver:	
a. Staff must receive the following training within one month of employment and prior to providing direct service without the presence of experienced staff:	
1. Orientation on provider's mission, policies, and procedures	Yes
2. Orientation on HCBS philosophy and outcomes for rights and dignity	Yes
b. Staff must receive the following training within four months of employment and prior to providing direct service without the presence of experienced staff:	
1. Training in serious emotional disturbance and provision of services to children with serious emotional disturbance	Yes
2. Confidentiality	Yes
3. Provision of medication according to agency policy and procedure	Yes
4. Identification and reporting of child abuse	Yes
5. Incident reporting	Yes
6. Documentation of service provision	Yes
7. Appropriate behavioral interventions	Yes
8. Professional ethics training	Yes
c. Twenty-four hours of training during first year of employment in children's mental health issues	Yes
d. Twelve hours of training every year thereafter in children's mental health issues	Yes
10. RBSCL (Residential-Based Supported Community Living)	
a. Orientation on agency's purpose, policies, and procedures within one month of hire	Yes
b. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues	Yes

c. Twelve hours of training every year thereafter in children's ID/DD/MH issues	Yes
11. Prevocational Services	
a. A person providing direct support shall, within six months of hire complete at least 9.5 hours of employment service training as offered through Direct Course or through the Association of Community Rehabilitation Educators (ACRE) certified training program	Yes
b. Prevocational direct support staff shall complete four hours of continuing education in employment services annually	Yes
12. Supported Employment	
a. Supported employment direct support staff shall complete four hours of continuing education in employment services annually	Yes
1. Long-term job coaching	
a. A person providing direct support must hold an associate degree or high school diploma or equivalent and 6 months relevant experience	Yes
b. A person providing direct support shall, within six months of hire or within six months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program	Yes
c. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching	Yes
2. Small-group supported employment	
a. A person providing direct support shall, within six months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program	Yes
b. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching	Yes
3. Individual supported employment	
a. A person providing direct support must hold a bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business	Yes
b. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

III.Policies and Procedures

42 CFR 441-310 (c)(4), 42 CFR 441-710, 45 CFR 164.508, Iowa Code 135C.33, 232.69 and 236B.3, IAC Chapters 77 and 79

Requirement A. Intake, Admission, Service Coordination, Discharge and Referral ***At a minimum, there will be evidence of:***	
1. An intake/admission process	Yes
2. A referral process	Yes
3. Service coordination (defined as activities designed to assist members and families locate, access and coordinate a network of supports and services within the community)	Yes
4. A discharge process	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement B. HCBS settings required for all providers ***At a minimum, there will be evidence of:***	
1. The setting is integrated in, and facilitates the member's full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community like members without disabilities	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

2. The setting is selected by the member among available alternatives and identified in the person-centered service plan	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
3. Members’ essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes

Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
4. Members’ initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
5. Members’ choice regarding services and supports, and who provides them, is facilitated	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes

Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation (SE)	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
6. All rights restrictions are time limited, contain the member’s informed consent, are supported by a specific assessed need and documented in the person-centered service plan	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation (SE)	Yes
If indicating “No,” describe plan to meet the standard(s):	

If indicating “NA,” describe why the standard(s) are not applicable to your agency:

Requirement B. 7 through 14 applies to services in provider-owned or controlled settings. As indicated in the approved Statewide Transition Plan (STP), services are provider-owned or provider-controlled if the following conditions are present:

If the HCBS provider leases from a third party or owns the property, this would be considered provider-owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, it would be presumed that the setting was provider-controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants. If the member leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled.

7. In provider-owned or provider-controlled setting, each member has privacy in their sleeping or living unit	
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Habilitation Services	
Home-based Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
8. In a provider owned or provider controlled setting, members sharing units have a choice of roommates in that setting	
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Habilitation Services	
Home-based Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
9. In a provider owned or provider controlled setting, members have the freedom and support to control their own schedules and activities, and have access to food at any time	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes

In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation (SE)	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
10. In a provider owned or provider controlled setting, members are able to have visitors of their choosing at any time	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation (SE)	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
11. In a provider owned or provider controlled setting, the setting is physically accessible to	

the member	
Adult Day Care	Yes
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Behavior Programming	Yes
Counseling	Yes
Day Habilitation	Yes
Family Counseling and Training	Yes
Family and Community Support Services	Yes
In-home Family Therapy	Yes
Interim Medical Monitoring and Treatment (IMMT)	Yes
Mental Health Outreach	Yes
Prevocational Services	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Supported Employment (SE)	Yes
Habilitation Services	
Day Habilitation	Yes
Home-based Habilitation	Yes
Prevocational Habilitation	Yes
Supported Employment Habilitation (SE)	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
12. Provider owned or provider controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity	
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Habilitation Services	
Home-based Habilitation	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	
13. Provider owned or provider controlled home has entrance doors to the member’s living and sleeping unit which can be locked by the individual with only appropriate staff having keys	
Agency Consumer-Directed Attendant Care (CDAC)	Yes

Assisted Living Service	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Habilitation Services	
Home-based Habilitation	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
14. In a provider owned or provider controlled home members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	
Agency Consumer-Directed Attendant Care (CDAC)	Yes
Assisted Living Service	Yes
Residential-Based Supported Community Living (RB-SCL)	Yes
Supported Community Living (SCL)	Yes
Habilitation Services	
Home-based Habilitation	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement C. Person Centered Planning *At a minimum, there will be evidence of:*	
1. Provider participation in interdisciplinary team meetings	Yes
2. The member's file contains a copy of the written person centered plan	Yes
3. The provider's plan is consistent with the case manager's person centered plan	Yes
4. The provider's service plan includes interventions and supports needed to meet member goals with incremental action steps, as appropriate	Yes
5. The provider's plan reflects desired member outcomes	Yes
6. The provider's service plan includes documentation of all rights restrictions, the need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	
Requirement D. Service Documentation *At a minimum, service documentation shall include:*	
1. Specific location, date, and times of service provision	Yes
2. Service(s) provided	Yes
3. Member's first and last name	Yes
4. Staff providing service(s), including first and last name, signature and professional	Yes

credentials (if any)	
5. Specific interventions, including name, dosage, and route of medications administered	Yes
6. Any supplies dispensed as part of the service	Yes
7. Member's response to staff interventions	Yes
8. Process to ensure units of service billed for payment are based on services provided with substantiating documentation	Yes
If indicating "No," describe plan to meet the standard(s):	
Requirement E. Personnel records required for all providers *At a minimum, there will be evidence of:*	
1. Completion of the following requirements is required prior to date of hire	Yes
a. Dependent adult and child abuse checks	Yes
b. Criminal history background and Department of Human Services (DHS) evaluation where applicable	Yes
c. Evaluation of hits by the Department of Human Services when applicable	Yes
d. Documentation of follow-through on any employment restrictions as stated in DHS evaluation	Yes
e. Verification of Office of Inspector General (OIG) excluded individual search Social Security Act, Sections 1128 and 1156	Yes
2. Job performance evaluations	Yes
If indicating "No," describe plan to meet the standard(s):	
Requirement F. Abuse Reporting *At a minimum, there will be evidence of:*	
1. A process staff must follow the agency's procedure to report allegations immediately (oral report within 24 hours; written report within 48 hours) to the Department of Human Services (DHS) or Department of Inspections and Appeals (DIA) when the environment is certified or licensed by this entity	Yes
2. A process staff must follow the agency's procedure to ensure the member's safety upon learning of an allegation	Yes
3. A process the provider will follow when the alleged perpetrator is an employee	Yes
4. A process for ensuring staff receive a statement of the abuse reporting requirements within one month of employment	Yes
If indicating "No," describe plan to meet the standard(s):	
Requirement G. Incident Reporting *At a minimum, there will be evidence of:*	
1. What constitutes an incident in accordance with the IAC definition	Yes
2. The mechanism for ensuring the routing of incidents to the:	
a. Supervisor by the end of the next calendar day after the incident (major); within 72 hours (minor)	Yes
b. Case manager/service worker by the end of the next calendar day after the incident (major)	Yes
c. Legal guardian by the end of the next calendar day after the incident (major)	Yes
d. Member by the end of the next calendar day after the incident if the incident took place outside service provision (major)	Yes
e. Bureau of Long-Term Care or appropriate entity by the end of the next calendar	Yes

day after the incident via direct data entry into Iowa Medicaid Portal Access (IMPA) or as determined by the department	
3. A centralized location for the filing of incident reports	Yes
4. A process for noting the completion of an incident report form in the member record	Yes
5. The submission of follow-up reports as requested by case manager/service/integrated health home care coordinator (major)	Yes
If indicating "No," describe plan to meet the standard(s):	
Requirement H. Safeguarding Consumer Information *At a minimum, there will be evidence that:*	
1. The provider has a process for maintaining confidential records and safeguarding personal member information	Yes
2. An expiration date or event is identified if a release of information form is utilized	Yes
If indicating "No," describe plan to meet the standard(s):	
Requirement I. Contracts with members *At a minimum, the agency shall have written procedures which provide for the establishment of an agreement between the member and the provider and evidence will be supplied that:*	
1. The agreement shall define the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, all room and board and co-pay fees to be charged to the member and the sources of payment	Yes
2. Contracts shall be reviewed at least annually	Yes
If indicating "No," describe plan to meet the standard(s):	
If indicating "NA," describe why the standard(s) are not applicable to your agency:	

IV. Quality Improvement

IAC Chapter 77

Requirement A. Quality Improvement (QI) *At a minimum, the plan will identify the:*	
1. Ongoing schedule or timeline for quality improvement activities, to include the specific timeframes for data collection, data analysis, and to identify entities with whom results will be shared	Yes
2. Discovery	
a. Collecting and reviewing data to identify issues to be monitored for quality improvement to include sample size and acceptable thresholds	Yes
b. Ongoing review of responses to all member/stakeholder input to determine the need for systemic changes	Yes
c. Ongoing review of member records to include medication management, health and safety, incident reporting, and documentation	Yes
d. Tracking and trending of incidents	Yes
3. Remediation. The development of a plan to address areas of improvement identified during discovery to include specific timelines for development and completion of action steps	Yes

4. Improvement. Summary of QI activities to include monitoring the impact of remediation plan	Yes
If indicating “No,” describe plan to meet the standard(s):	
If indicating “NA,” describe why the standard(s) are not applicable to your agency:	

Section D. CMS Final Setting Rule

During any HCBS Quality Oversight review process has your agency been required to submit a corrective action plan related to the requirements identified **in Section II. Requirement B. HCBS Settings Rule** or **Section II. Requirement C. Person-Centered Planning**? 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)	Yes
If “Yes,” your agency must submit a status update to your corrective action plan to provide evidence that your agency is on track to meet compliance in this area. Include update below.	

Iowa Department of Human Services

2018 Provider Quality Management Self-Assessment

Section E. Guarantee of Accuracy

Click for help

In submitting this Self-Assessment or signing this Guarantee of Accuracy, the agency and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Further, the agency and all signatories each acknowledge
(1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate regional HCBS Specialist (see contact instructions on page one) in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis,
as initiated by random sampling or as a result of a complaint. **NOTICE: Any person that submits a**
false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.

Indicate which accreditation, licensure or certification held, including those which qualify your agency to provide HCBS. Include dates of accreditation/licensure/certification for each selection chosen (MM/YY begin – MM/YY end):

Check Box	Accreditation, Licensure or Certification	Start Date	End Date
☐	Council on Accreditation		
☐	CARF International		
☐	Iowa Department of Public Health		
☐	The Council on Quality and Leadership (CQL)		
☐	Department of Inspections and Appeals		
☐	The Joint Commission (TJC)		
☐	Chapter 24		
☐	Other:		

Question	Response
Is your organization in good standing with the accreditation/licensing/certifying organization? *If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed 2018 HCBS Provider Quality Management Self-Assessment.	Yes
Is this organization in good standing with the Iowa Secretary of State's Office?	Yes

PRINT NAME of ***Agency***

PRINT NAME of ***Executive Director***

SIGNATURE of ***Executive Director*** ***Date***

PRINT NAME of ***Chairperson, Board of Directors***

SIGNATURE of ***Chairperson, Board of Directors*** ***Date***

2018 Provider Quality Management Self-Assessment

Section F. Direct Support Professional Workforce Data Collection

Instructions

For the purposes of these questions, a direct support professional is an individual who provides supportive services and care to people who are elderly, experiencing illnesses, or disabilities. This definition *excludes* individuals working as nurses, social workers, counselors, and case managers.

Individuals providing the following waiver services should be considered direct support professional workers:

- Adult Day Care
- Behavioral Programming
- CCO
- CDAC
- Family and Community Support Services
- Home Health
- Homemaker
- Interim Medical Monitoring and Treatment
- Prevocational Services
- Respite
- Residential SCL
- SCL
- Supported Employment

1. Please list your organization's total number of full-time and part-time employees (including contract employees).

   Total number of full-time and part-time employees

   Of this total, please list the number of full-time and part-time employees providing direct support services according to the definition provided above. Please include supervisors and coordinators who provide direct support services.

   Number of full-time direct care workers (including contract employees)

   Number of part-time direct care workers (including contract employees)

2. The U.S. Department of Labor utilizes the following three titles and definitions to gather information on the direct support professional workforce.

   Please list the number of individuals you employ in the following three categories. Choose the category that best reflects services provided. Individuals do not need to be certified as a home health aide or nurse aide to be included in those categories. An individual cannot be counted in more than one category.

   Personal and Home Care Aides
   Often called direct support professionals, these workers provide support services such as implementing a behavior plan, teaching self-care skills, and providing employment support, as well as providing a range of other personal assistance services. They provide support to people in their homes, residential facilities, or in day programs, and are supervised by a nurse, social worker, or other non-medical manager.

   Number of personal and home care aides (including contract employees)

   Home Health Aides
   Home health aides typically work for home health or hospice agencies and work under the direct supervision of a medical professional. These aides provide support to people in their homes, residential facilities, or in day programs. They help with light housekeeping, shopping, cooking, bathing, dressing, and grooming, and may provide some basic health-related services such as checking pulse rate, temperature, and respiration rate.

   Number of home health aides (including contract employees)

   Nursing Aides

   Most nursing aides have received specific training for the job and some have received their certification as a Certified Nursing Assistant (CNA) in Iowa. According to the Department of Labor, nursing aides provide hands-on care under the supervision of nursing and medical staff in hospitals and nursing care facilities, although they do work in home- and community-based settings as well. Nursing aides often help members eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording members' physical, mental, and emotional conditions.

   Number of nursing aides (including contract employees

Attachment B Non-Residential Review Tool

Settings Review Report

Review Number:

I. HCBS Settings required for all providers	Self-Assessment	Included In Policy	Evidence Submitted	CAP Required
For all providers at a minimum, community integration will be supported by:				
1) The setting is integrated in and facilitates the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community,				
2) The setting is selected by the individual among all available alternatives and identified in the person-centered service plan				
3) An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected				
4) Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not				
5) Individual choice regarding services and supports, and who provides				
6) Any rights restriction (for example to address the safety needs of an individual with dementia) must be time limited, contain member's informed consent, supported by a specific assessed need and				
7) In a provider owned or provider controlled setting, each individual has privacy in their sleeping or living unit				
8) In a provider owned or provider controlled setting, individuals sharing units have a choice of roommates in that setting				
9) In a provider owned or provider controlled setting, individuals have the freedom and support to control their own schedules and activities,				
10) In a provider owned or provider controlled setting, individuals are able to have visitors of their choosing at any time				
11) In a provider owned or provider controlled setting, the setting is physically accessible to the individual				
12) Provider owned or provider controlled home is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of				

13) Provider owned or provider controlled home has entrance doors lockable by the individual, with only appropriate staff having keys to				
14) In a provider owned or provider controlled home, individuals have the freedom to furnish and decorate their sleeping or living units within				
Review Findings:				
II. Person Centered Planning	**Self-Assessment**	**Included In Policy**	**Evidence Submitted**	**CAP Required**
For all providers at a minimum, the service plan will identify:				
1) Provider participates in Interdisciplinary team meetings				
2) Member file contains a copy of the written person centered plan				
3) Provider's plan is consistent with the case manager's person centered				
4) Provider's service plan includes interventions and supports needed to meet the individual goals with incremental action steps, as appropriate				
5) Provider's plan reflects desired individual outcomes				
6) Provider's service plan includes documentation of any rights restrictions, why there is a need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate				
Review Finding				
III. Providers are required to develop and implement a Quality Improvement (QI) plan. This plan must have a systematic, organization wide, planned approach to designing, measuring, evaluating and improving the agency performance	**Self-Assessment**	**Included In Policy**	**Evidence Submitted**	**CAP Required**
Quality Improvement (QI) At a minimum, the plan will identify the:				
1) Ongoing schedule or timeline for quality improvement activities, to include specific timeframes for data collection, data analysis and to identify entities with whom results will be shared				
2) Discovery: 2.a) Collecting and reviewing data to identify issues to be monitored for quality improvement to include sample size and				
2.b) Ongoing review of responses to all member/stakeholder input to determine the need for systemic changes				
2.c) Ongoing review of member records to include medication management, health and safety, incident reporting and documentation				
3) Remediation: The development of a plan to address areas of improvement identified during discovery, to include specific timelines for development and completion of action steps				
4) Improvement: Summary of QI activities to include monitoring the impact of remediation plan				
Review Findings:				

Attachment C- Residential Assessment Tool

Iowa Department of Human Services

Home- and Community-Based Services (HCBS) Residential Setting Member Assessment

I. Member information		
Member Name:	Member ID:	
Address:		
City:	Iowa	Zip:
HCBS Waiver:		
Services Received:		
HCBS Service Providers:		
Assessment Completed By:		Date:
DHS/MCO/IHH Unit:		
Please check: Initial Assessment Annual Assessment		
Number of Waiver or Habilitation members living in the setting:		

Member's residential setting (part 1). Please check all that apply. The member: Lives with their family or legal representative

Owns their home, or

Rents a living unit from a community landlord that is not owned or operated by a HCBS service provider

These settings are presumed to be integrated community settings. Members that meet one of these three settings and do not meet any criteria in part 2 below are required to only complete section I. *Member information* of this assessment.

Member's residential setting (part 2). The following residential settings require additional review to determine compliance with the HCBS setting rules. Please check all that apply. The member lives in a setting that is:

Located on the grounds of or directly adjacent to a public or private institution. A licensed facility (residential care, assisted living, other).

Where two or more members receiving Medicaid funded services live together to receive waiver/habilitation service.

Where multiple HCBS/habilitation living units are co-located in close proximity to each other within the community.

Owned or operated by the provider of service.

Members that meet any part 2 criteria shall have Section III. *Member Outcomes* of the HCBS Residential Setting Member Assessment completed by the assigned case coordinator (CBCM, CM or IHH). Assessments shall be conducted in person and in the home where the member lives. Initial assessments shall be conducted by December 31, 2017, and annually thereafter.

Please submit completed electronic assessments to:

II. Instructions to Complete the Residential Assessment

Below are nine personal outcomes expected to be present in a member's life. Each outcome is listed separately and has a series of questions to be answered by the interviewer to assist with determining whether or not the outcome is present in the life of the member. The presence of these outcomes identifies characteristics of living in integrated community settings. There is no right or wrong answer to the outcome questions as the outcome defines the experience of the member in their residential setting.

The list of questions is not inclusive and the interviewer may ask additional questions based on the response from the member. The interview must include the member and may include others (parents, guardians, provider staff, etc.) as needed. By asking the questions, the interviewer must have enough information to answer either yes or no on the final outcome question at the end of each section. If the interviewer cannot make a final determination, additional guidance questions are needed. For each Yes or No response, the interviewer must provide evidence that supports the final response.

III. Member Outcomes

1. Members Choose where and with whom they live.

Guidance questions:

- Was the member given a choice of available options regarding where to live/receive services?
- Is the setting in the community among other private residences?
- Was the member given the opportunity to visit other settings?
- Does the setting reflect the member's needs and preferences?
- Was the member given a choice of roommates?
- Does the member talk about his/her roommates in a positive manner?
- Does the member have a choice in whether to share a room with a roommate?
- If married, does the married couple have a choice in whether to share or not share a room?
- Does the member know how the member can request a roommate change?
- Does the member have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement?
- Does the member know his/her rights regarding housing and when the member could be required to relocate?

Did the member choose where and with whom to live? (Yes or No) Yes No

If YES, describe evidence/supporting documentation used to determine the response.

If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.

2. Members choose their daily routine.

Guidance questions:

- Can the member come and go from the residence at any time?
- Does the member talk about activities occurring outside of the setting?
- Does the member participate in scheduled and unscheduled community activities?
- Does the member choose when to get up in the morning, bathe, eat, exercise, participate in activities, etc.?
- Does the member's schedule vary from others in the same setting?
- Does the member have access to such things as a television, radio, and leisure activities that interest him/her and can the member participate in such activities at his/her convenience?
- Does the member choose when and with whom to eat meals?
- Can the member request or prepare an alternative meal if desired?
- Does the member have access to snacks anytime?
- Is the member required to sit at an assigned seat in a dining area?
- If the member desires to eat privately, can the member do so?

Does the member make choices about day-to-day activities and routines? (Yes or No) Yes No

If YES, please describe evidence/supporting documentation.

If NO, identify how this is addressed in the member's person-centered plan.

3. Members choose where they work or receive day services.
Guidance questions: • Does the member work in an integrated community setting? • Was the member given a choice of available options regarding where to work? • If the member would like to work, is there activity that ensures the option is pursued? • Was the member given the opportunity to visit other settings before making a choice? • Does the member participate in a day activity program? • Was the member given a choice of available options regarding where to receive day services including non-disability specific services? • When receiving day services, does the member participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the member? • Does the member have the opportunity to combine more than one service or type of day activity in any given day/week (e.g., combine competitive employment with community habilitation or day habilitation)?
• Does the member have residential service options available if work or day services are not chosen on any given day/week?
Does the member have the opportunity to seek employment and work in competitive integrated settings? (Yes or No) Yes No
When not working, is the member active in the community outside of the residential setting and have opportunity to participate in integrated day services during typical work time hours of the day? (Yes or No) Yes No
If YES to either question, describe the evidence/supporting documentation used to determine the response. If NO to either, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.
4. Members manage personal resources.
Guidance questions: • Does the member have a checking or savings account or other means to control his/her personal finances? • Does the member have access to his/her personal finances? • Is the member required to sign over his/her paychecks to the provider? • When needed, does the member receive support from direct care staff to manage personal funds? • Does the member have a representative payee or other legal representative to assist with personal finances?
Does the member manage personal resources to the degree desired by the member? (Yes or No) Yes No
If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.
5. Members are treated with dignity and respect.

Guidance questions:

- Does staff ask the member about her/his needs and preferences?
- Are members aware of how to make a service request?
- Does the member express satisfaction with the services received?
- Are requests for services and supports accommodated as opposed to ignored or denied?
- Is member's choice facilitated in a manner that leaves the member feeling empowered to make decisions?
- Is health information about members kept private?
- Are schedules of members for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?
- Are members, who need assistance with grooming, groomed as they desire?
- Are monitoring cameras present in the setting?
- Do staff or other residents always knock and receive permission before entering an individual's living space?
- Do members greet and chat with staff?
- Do staff converse with members in the setting while providing assistance and during the regular course of daily activities?
- Does staff talk to other staff about a member as if the member was not present or within earshot of other persons living in the setting?
- Does staff address members in the manner in which the person would like to be addressed as opposed to routinely addressing members as 'hon' or 'sweetie'?

Is the member treated with respect? (Yes or No)	Yes	No
Does the setting assure member privacy? (Yes or No)	Yes	No

If YES to either, describe evidence/supporting documentation used to determine the response.

If NO to either, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.

6. Members use community resources.

Guidance questions:

- Does the member have the opportunity to regularly access community resources?
- Is the member able to describe how the member accesses the community, who assists in facilitating the activity and where the member goes?
- Is the member aware of or have access to materials to become aware of activities occurring outside of the setting?
- Does the member shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as the member chooses?
- Do members come and go at will?
- Are members moving about inside and outside the setting as opposed to sitting by the front door?
- Is there a curfew or other requirement for a scheduled return to the setting?
- Do members in the setting have access to public transportation?
- Where public transportation is limited, are other resources provided for the member to access the broader community?
- Are there bus stops nearby or are taxis available in the area?
- Is an accessible van available to transport members to appointments, shopping, etc.?
- Are bus and other public transportation schedules and telephone numbers available to the member?
- Is training in the use of public transportation facilitated?

Does the member have opportunity to use the resources of the community? (Yes or No)	Yes	No
Does the member participate in community activities of interest to the degree desired by the member? (Yes or No)	Yes	No
If YES to either, describe evidence/supporting documentation used to determine the response. If NO to either, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.		
7. Members have access to their home and community.		
Guidance questions: • Are there gates, Velcro strips, locked doors, or other barriers preventing members' entrance to or exit from certain areas of the setting? • Are members receiving Medicaid Home- and Community-Based services facilitated in accessing community-based amenities such as a pool or gym used by others? • Is the setting physically accessible and are there no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting members' mobility in the setting or, if they are present, are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction? • For those members who need supports to move about the setting as they choose, are supports provided, such as grab bars in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.? • Are appliances accessible to members (e.g., the washer/dryer is front loading for members in wheelchairs)? • Are tables and chairs at a convenient height and location so that members can access and use the furniture comfortably?		
Is the member's home and community accessible to meet the individual needs of the member? (Yes or No)	Yes	No
If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.		
8. Member exercise their rights and responsibilities.		
Guidance questions: • Are all limitations of individual rights clearly identified in the member's person-centered plan? • Is the member supported in voting in local, state, and national elections? • Is information about filing a complaint given to a member and in an understandable format? • Is the member comfortable discussing concerns? • Can the member file an anonymous complaint? • Does the member know the person to contact or the process to make an anonymous complaint? • Does staff impose arbitrary limits on a member? • Does the member have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement? • Does the member know his/her rights regarding housing and when the member could be required to relocate? • Do members know how to relocate and request new housing? • Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord-tenant laws?		
Does the member understand and exercise their rights and responsibilities? (Yes or No)	Yes	No

If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.
9. Services are individualized to the needs of the member.
Guidance questions: Does the member, or a person chosen by the member, have an active role in the development and update of the person-centered plan? Are individual wants, needs, and preferences incorporated into the member's person-centered service plan? If needed, does the member know how and to whom to make a request for a new provider? Is the member or a person chosen by the member, aware of how to schedule person-centered planning meetings? Can the member explain the process to develop and update a service plan? Was the member present during the last planning meeting? Did/does the planning meeting occur at a time and place convenient for the member to attend? Can the member identify other providers who render the services they receive? Does the member express satisfaction with the provider selected or has the member asked for a meeting to discuss a

Are services provided to the member based on a person-centered plan developed to meet individual needs? (Yes or No)	Yes	No
If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.		
IV. The Bottom Line		
Based on the finding of the nine member outcomes above, answer yes or no to the following statements:		
The member has access and opportunity to use the community resources to meet individual needs and preferences.	Yes	No
The residential setting supports the member to live, work, and recreate in the community to the degree desired by the member.	Yes	No
All rights limitations that limit access to the greater community are documented in the member's person-centered plan	Yes	No

Attachment D Promulgated Rules

ARC 3784C

HUMAN SERVICES DEPARTMENT [441]

Notice of Intended Action

Proposing rule making related to settings for home- and community-based services and providing an opportunity for public comment

The Human Services Department hereby proposes to amend Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4, 42 CFR Section 441.301(c) and 42 CFR Section 441.710.

Purpose and Summary

The Centers for Medicare and Medicaid Services (CMS) has issued regulations that define the residential and nonresidential settings in which it is permissible for states to provide and pay for Medicaid home- and community-based services (HCBS). The purpose of the CMS regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. These regulations also aim to ensure that individuals have a free choice of where they live and who provides services to them, as well as to ensure that individual rights are not restricted. While providing Medicaid HCBS in institutional settings has never been allowed, these new regulations clarify that HCBS may not be provided in settings that have the qualities of an institution. The federal regulations were effective March 17, 2014, with an initial five-year transition time period for all HCBS providers to be in full compliance with the regulations or lose federal HCBS funding for services provided in the setting. Due to the complexity of the changes required for full compliance, CMS extended the implementation time period by three years on May 9, 2017. The State has until March 17, 2022, to demonstrate full compliance with the HCBS settings regulations.

As part of a statewide transition plan developed to transition HCBS services to meet the federal regulations, CMS required the State of Iowa to complete a full assessment of the administrative rules in the Iowa Administrative Code for compliance with the federal regulations. These proposed amendments make changes to the Department's administrative rules necessary for full compliance with federal regulations as cited above.

Fiscal Impact

This rule making's fiscal impact to the State of Iowa cannot be determined. Issues with a specific provider setting or services that do not meet the settings guidelines would cause cost increases. These increases could be due to a member's change in services, such as a switch to supported employment, and to changes in staffing ratios within the services. The settings rules will also require that more services be provided in community-based settings. There will be increased provider costs involving transportation and smaller staff-to-member ratios when providers take members into the community with some type of regularity. CMS did not offer any increase in rates for services in conjunction with the new setting requirements. It is also difficult to quantify the number of members affected or how soon cost increases will be realized. Therefore, the fiscal impact cannot be determined.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on May 29, 2018. Comments should be directed to:

Harry Rossander
Bureau of Policy Coordination
Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: policyanalysis@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)"b," an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend rule 441—77.25(249A), introductory paragraph, as follows:

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), ~~and~~ 77.25(4), and 77.25(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

ITEM 2. Adopt the following new definition of "Provider-owned or controlled setting" in subrule 77.25(1):

"Provider-owned or controlled setting" means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member.

ITEM 3. Renumber subrules 77.25(5) to 77.25(9) as 77.25(6) to 77.25(10).

ITEM 4. Adopt the following new subrule 77.25(5):

77.25(5) *Residential and nonresidential settings.* Effective March 17, 2022, all home- and community-based services (HCBS), whether residential or nonresidential, shall be provided in integrated, community-based settings that support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Settings shall optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

a. Nursing facilities, institutions for mental diseases, intermediate care facilities for persons with an intellectual disability, and hospitals are not considered integrated, community-based settings.

b. Any HCBS setting that is located in a building that is also a publicly or privately operated facility, identified in paragraph 77.25(5)*"a,"* that provides inpatient treatment or in a building on the grounds of, or immediately adjacent to, a public institution, identified in paragraph 77.25(5)*"a,"* or any setting that has the effect of isolating members receiving Medicaid HCBS from the broader community will be presumed to be a setting that has the qualities of an institution unless the department conducts a site-specific review and determines otherwise.

c. Residential services may be provided in provider-owned or controlled settings. In provider-owned or controlled residential settings:

(1) The member selects the setting from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.

(2) The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and resources available for room and board.

(3) Members have choices regarding services and supports received and who provides them.

(4) Members are assured the rights of privacy, dignity, respect, and freedom from coercion and undue restraint.

(5) Services and supports shall optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

(6) Each member shall be afforded privacy in the member's sleeping and living unit. Living unit entrance doors and bedroom doors may be locked by the member, and only appropriate staff shall have keys. Staff access to keys must be identified in the member's person-centered plan.

(7) Members shall have a choice of roommates in that setting.

(8) Members shall have the freedom to furnish and decorate their sleeping or living areas as desired as permitted by any operative lease or other agreement.

(9) Members shall have the freedom and support to control their own schedules and activities and shall have access to food at any time.

(10) Members may have visitors of their choosing at any time.

(11) The setting shall be physically accessible to the member.

ITEM 5. Amend rule 441—77.30(249A), introductory paragraph, as follows:

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following

providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

ITEM 6. Amend rule 441—77.33(249A), introductory paragraph, as follows:

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

ITEM 7. Amend rule 441—77.34(249A), introductory paragraph, as follows:

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

ITEM 8. Amend rule 441—77.37(249A) as follows:

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not

be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS intellectual disability waiver service providers.

77.37(1) to 77.37(32) No change.

This rule is intended to implement Iowa Code section 249A.4.

ITEM 9. Amend rule 441—77.39(249A) as follows:

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS brain injury waiver service providers.

77.39(1) to 77.39(30) No change.

This rule is intended to implement Iowa Code section 249A.4.

ITEM 10. Amend rule 441—77.41(249A), introductory paragraph, as follows:

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers. The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS physical disability waiver service providers.

ITEM 11. Amend rule 441—77.46(249A), introductory paragraph, as follows:

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and the integrated, community-based settings standards in subrule

77.25(5) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

ITEM 12. Amend rule 441—78.27(249A), introductory paragraph, as follows:

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.

ITEM 13. Amend subrule 78.27(1), definition of "Comprehensive service plan," as follows:

"Comprehensive service plan" means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

ITEM 14. Amend paragraph 78.27(4)"a" as follows:

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team ~~for~~ as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) to (8) No change.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, or integrated health home care coordinator~~, or service worker~~ within 30 calendar days after plan approval.

(10) No change.

ITEM 15. Amend paragraph 78.27(8)"b" as follows:

b. Setting. Day habilitation shall take place in ~~a~~ community-based, nonresidential ~~setting~~ settings separate from the member's residence. ~~Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.~~

ITEM 16. Amend rule 441—78.34(249A), introductory paragraph, as follows:

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal

resources, and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.

ITEM 17. Amend subparagraph 78.34(8)"d"(4) as follows:

(4) Interim medical monitoring and treatment services shall be provided ~~only~~ in the following settings that are approved by the department as integrated, community-based settings: the member's home; ~~in~~ a registered child development home; ~~in~~ a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

ITEM 18. Reletter paragraphs 78.34(14)"c" and "d" as 78.34(14)"d" and "e."

ITEM 19. Adopt the following new paragraph 78.34(14)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 20. Amend rule 441—78.37(249A), introductory paragraph, as follows:

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 21. Reletter paragraphs 78.37(19)"c" and "d" as 78.37(19)"d" and "e."

ITEM 22. Adopt the following new paragraph 78.37(19)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 23. Amend rule 441—78.38(249A), introductory paragraph, as follows:

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 24. Reletter paragraphs 78.38(10)"c" and "d" as 78.38(10)"d" and "e."

ITEM 25. Adopt the following new paragraph 78.38(10)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 26. Amend rule 441—78.41(249A), introductory paragraph, as follows:

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 27. Amend subparagraph 78.41(9)"d"(4) as follows:

(4) Interim medical monitoring and treatment services shall be provided ~~only~~ in the following settings that are approved by the department as integrated, community-based settings: the member's home; ~~in~~ a registered child development home; ~~in~~ a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

ITEM 28. Reletter paragraphs 78.41(16)"c" and "d" as 78.41(16)"d" and "e."

ITEM 29. Adopt the following new paragraph 78.41(16)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 30. Amend rule 441—78.43(249A), introductory paragraph, as follows:

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 31. Amend subparagraph 78.34(8)"d"(4) as follows:

(4) Interim medical monitoring and treatment services shall be provided ~~only~~ in the following settings that are approved by the department as integrated, community-based settings: the member's home; ~~in~~ a registered child development home; ~~in~~ a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

ITEM 32. Reletter paragraphs 78.43(16)"c" and "d" as 78.43(16)"d" and "e."

ITEM 33. Adopt the following new paragraph 78.43(16)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 34. Amend rule 441—78.46(249A), introductory paragraph, as follows:

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 35. Reletter paragraphs 78.46(7)"c" and "d" as 78.46(7)"d" and "e."

ITEM 36. Adopt the following new paragraph 78.46(7)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 37. Amend rule 441—78.52(249A), introductory paragraph, as follows:

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ITEM 38. Reletter paragraphs 78.52(1)"c" and "d" as 78.52(1)"d" and "e."

ITEM 39. Adopt the following new paragraph 78.52(1)"c":

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

ITEM 40. Amend rule 441—83.1(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process,~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 41. Amend rule 441—83.21(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process,~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 42. Amend rule 441—83.41(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process,~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 43. Amend rule 441—83.60(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process,~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 44. Amend rule 441—83.81(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process,~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 45. Amend rule 441—83.101(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written consumer-centered~~ person-centered, outcome-based plan of services ~~developed using an interdisciplinary process~~ which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. ~~It may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

ITEM 46. Amend rule 441—83.121(249A), definition of "Service plan," as follows:

"Service plan" means a ~~written, consumer-centered~~ person-centered, outcome-based plan of services ~~developed by the consumer's interdisciplinary team~~ that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. ~~The service plan may involve more than one provider.~~ The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

Attachment E1- Member Transition Operational Procedure

Quality Improvement Organization (QIO) Home and Community Based Services (HCBS) Member Transition

Purpose: To ensure continuation of services and care coordination occurs for all members during an agency closure.

Identification of Roles:

QIO HCBS Operations Manager receives notification of an agency closing and assigns a QIO HCBS Specialist or QIO HCBS Support Staff to send the agency the closure tracking log.

QIO HCBS Specialist sends the agency the closing tracking log and completes weekly follow up, documenting each member's transition.

QIO HCBS Support Staff sends the agency the closing tracking log and completes weekly follow up, documenting each member's transition.

Path of Business Procedure:

Step 1: QIO HCBS Operations Manager receives notification of an agency closing and assigns a QIO HCBS Specialist or QIO HCBS Support Staff to send the agency the closure tracking log.
Step 2. The assigned QIO personnel sends the agency the agency closure spreadsheet with instructions on completing all information for each member served by the agency.
Step 3. The QIO receives the report back from the agency and follows up weekly with each case manager, monitoring the member transition.
Step 4. The QIO manager notifies policy of the transition and sends policy a weekly update of the transition.
Step 5. The transition monitoring continues until all members have been transitioned to another agency for services.

Forms/Reports/Materials:

Agency Closure log

Attachments:

Agency closure spreadsheet_blank.x

Attachment E2- Member Transition Spreadsheet

Name	SID	MCO	CM Name/Contact Info	Date Contacted	Transition plan in place	Notes

Attachment F- Incident and Complaint Operational Procedure

Business Unit:	State Medicaid	Approved By:	Shannon Miller
State Account:	Iowa - IME	Approved Date:	August 1, 2019
Business Function:	QIO Services	Effective Date:	August 1, 2019
Review Type:	Incident and Complaints	Review	
Timing:		Next Review Date:	August 1, 2020
Author:	Lisa Roush	Version #:	2

Procedure Purpose

To identify and follow-up on major incidents as identified in Iowa Administrative Code (IAC), complaints submitted regarding agencies who provide Home and Community Based Services (HCBS) to fee-for-service members, and allegations of abuse. Once an issue has been identified as requiring follow-up, the Incident and Complaint Specialist will request information to determine if a targeted review is required.

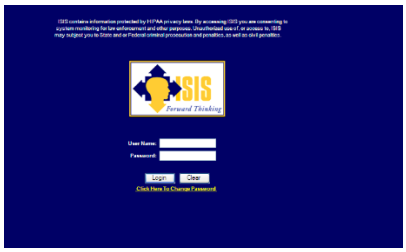
References
Iowa Administrative Code (IAC)

Systems
Onbase
MMIS
ISIS

Procedure Steps

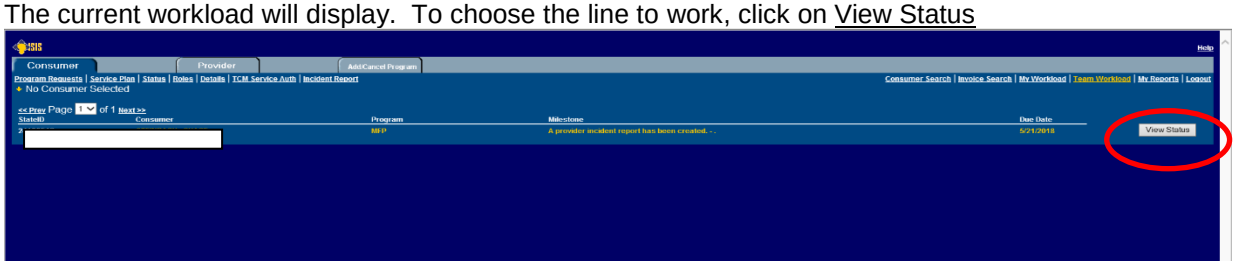
Incidents

Critical Incident Report Received in IMPA and Generates a milestone
How to Access Milestones: https://secureapp.dhs.state.ia.us/ISIS/login2.asp
Log into ISIS using assigned User Name and Password



Click on Team Workload function and Get Workload

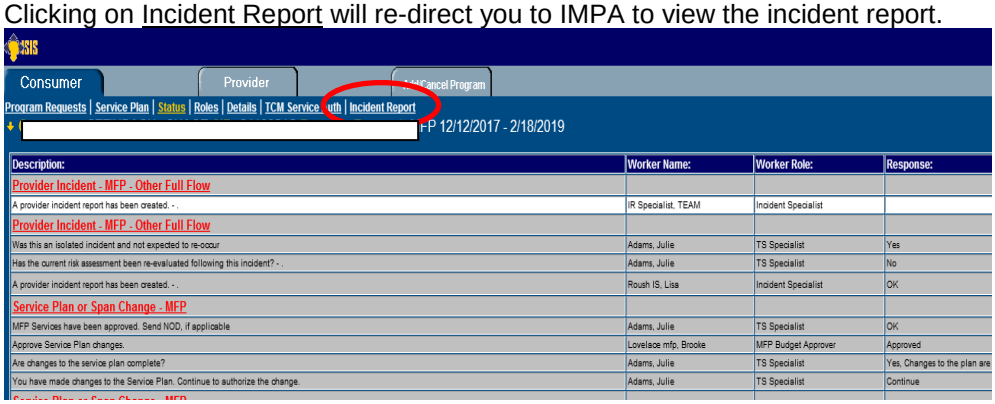
The current workload will display. To choose the line to work, click on View Status



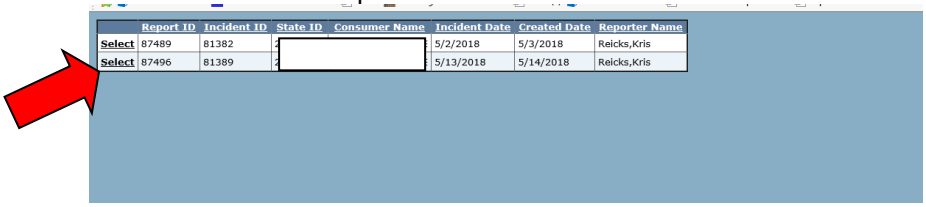
Milestone:

"A provider incident report has been created"

Clicking on Incident Report will re-direct you to IMPA to view the incident report.



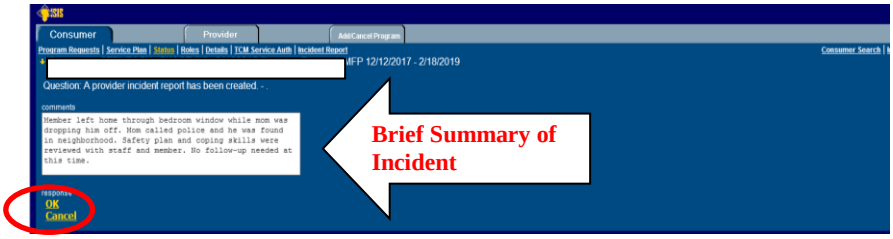
Select the Critical Incident Report to be reviewed. HCBS Incident and Complaint Specialist will review the Critical Incident Report



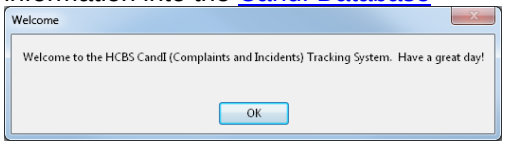
A summary of the incident will be inserted into comment box and indicate if follow-up is required. If no follow-up is required, then enter brief summary of incident and indicate that no follow-up is required at this time and click OK.

Reasons for Follow-Up (not an exclusive list)

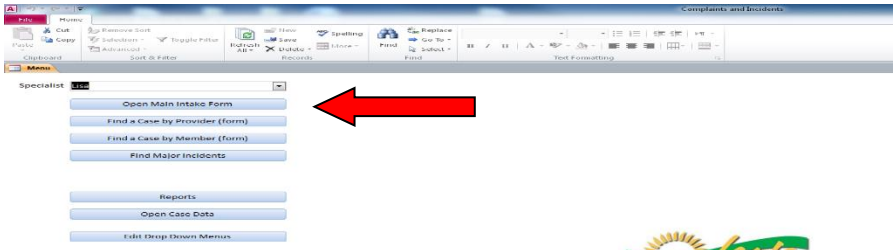
- *Death (ALL deaths require follow-up)*
- *Not enough details on report*
- *No resolution defined on report*
- *DHS has been contacted to investigate*



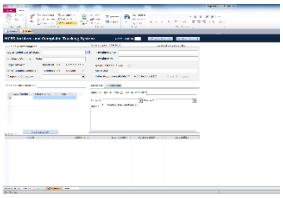
If follow-up is required then the HCBS Incident and Complaint Specialist will enter the following information into the CandI Database



Click “Open Main Intake Form” to create a new case

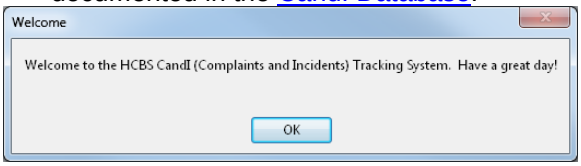


Enter information into all applicable fields that apply to the case being reviewed

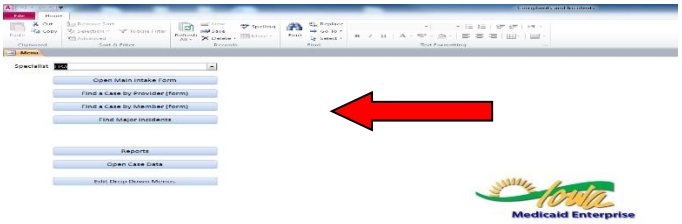


Depending on the type of follow-up will determine on how to proceed

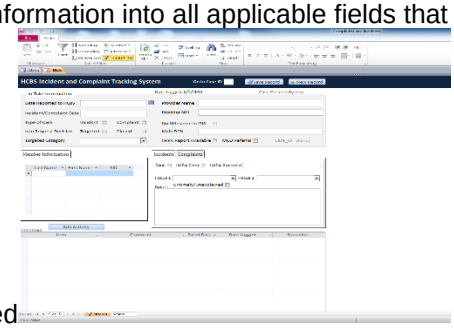
- Additional information requested from the Case Manager or the Provider to identify the outcome of a situation (committal, team meeting, death, additional staff training, staff suspension, staff termination, updated service plan, etc) will be added to the CandI Database and closed if HCBS Incident and Complaint Specialist is satisfied with the outcome of the incident.
- Additional information requested from the Case Manager or the Provider that may require further investigation will require the HCBS Incident and Complaint Specialist to create the *Complaint Req Info*. Enter the information into the CandI Database. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.

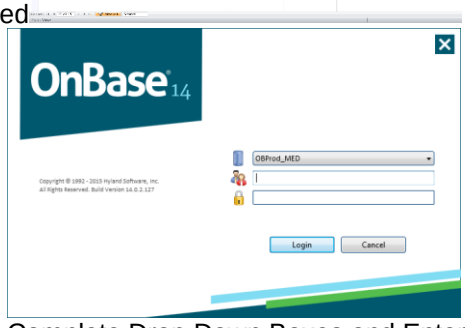


Click “Open Main Intake Form” to create a new case

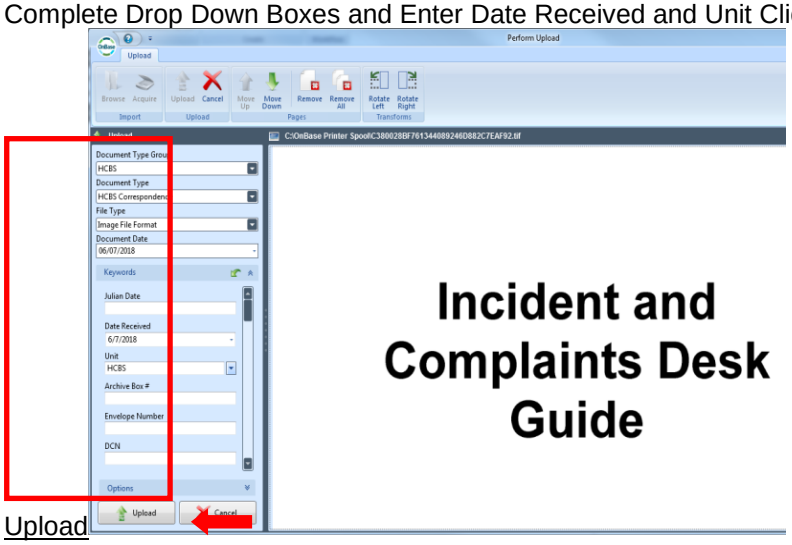


Enter information into all applicable fields that apply to the case being reviewed



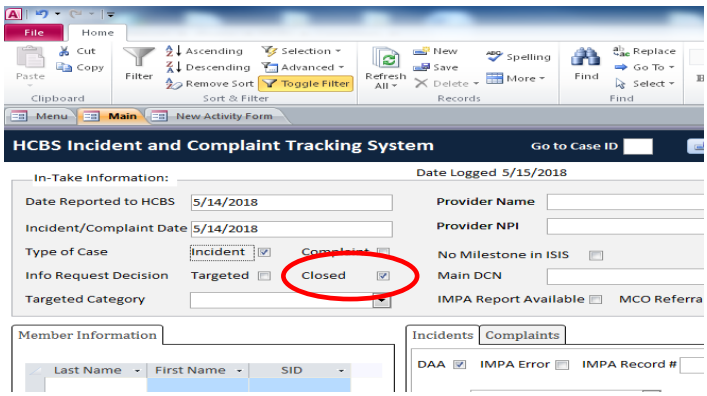


Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required then the letter titled *Complaint Review NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.
- Information not received within 15 business days will require the letter titled *Complaint Req Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP. If CAP information is not received within 30 business days, then the letter titled *CAP Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested CAP information.
- Once the CAP information is received and reviewed, the HCBS Specialist has 15 business days to accept or deny the CAP. If the CAP is accepted then the letter titled *CAP Review Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.

- If the CAP information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *CAP Review Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database. The provider will have 10 business days to submit acceptable CAP.
- A compliance review will be initiated with 45 business days of the CAP being accepted. The letter titled *Compliance Review Initiation* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database. The provider will have 15 business days to submit requested compliance material.
- If compliance material is not received within 15 business days, then the letter titled *Compliance Review Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database. The provider will have 10 business days to submit the requested compliance material.
- The HCBS Incident and Complaint Specialist has 15 business days to review information and determine if a compliance is accepted. Once the compliance information is accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database. The targeted review will be closed.
- If the compliance information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database. The provider will have 10 business days to submit compliance material.
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the Candl Database.



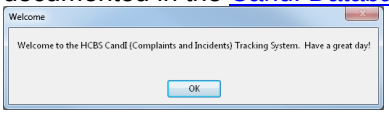
Critical Incident without a milestone

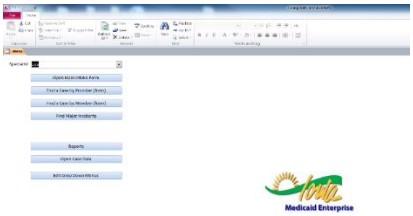
- Each Monday the Data Analyst will run a query from ISIS and IMPA to obtain a report of incident reports with no milestones.
- The information will be added to the spreadsheet titled, "IMPA Incidents wo ISIS Milestones"
- The HCBS Incident and Complaint Specialist will utilize IMPA to review the incident report HCBS Incident and Complaint Specialist will enter brief summary of incident into the spreadsheet under the "issue" category, enter yes/no if follow-up is required, and what type of follow-up is initiated.
    - If follow-up is required enter the information into the Candl Database
        - *Reasons for Follow-Up (not an exclusive list)*
            - *Death (ALL deaths require follow-up)*
            - *Medication Error*
            - *Lack of supervision and no resolution defined on report*
            - *Member service plan was not followed (i.e. restraints, rights restrictions, supervision, etc)*
            - *Abuse/Injury and no explanation or resolution defined on report*

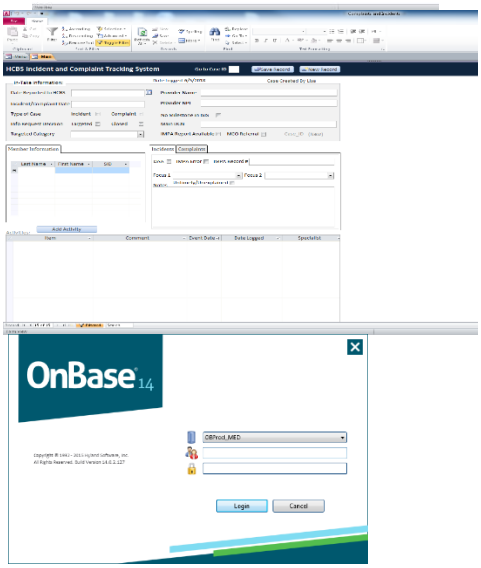
  Depending on the type of follow-up will determine on how to proceed
- Information will be requested from the Case Manager or the Provider to identify the outcome of a situation (death, additional staff training, staff suspension, staff termination, updated service plan, etc)

and will be added to the Candl Database and closed if HCBS Incident and Complaint Specialist is satisfied with the outcome of the incident.

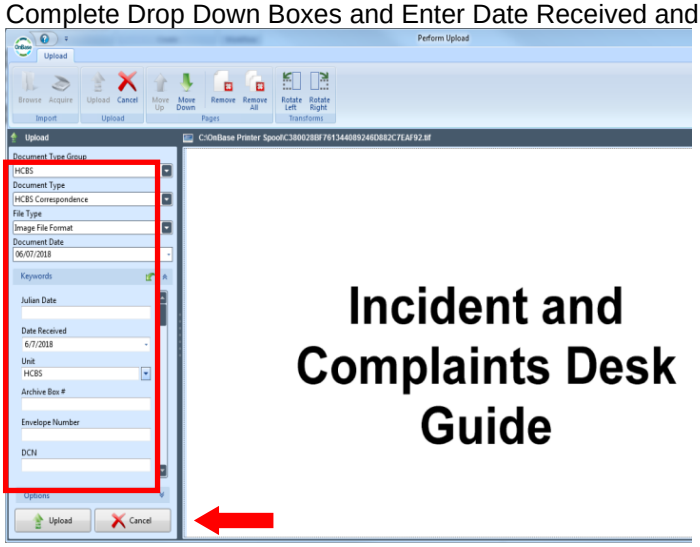
- Additional information requested from the Case Manager or the Provider that may require further investigation will require the HCBS Incident and Complaint Specialist to create the *Complaint Req Info*. Enter the information into the Candl Database. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the Candl Database.







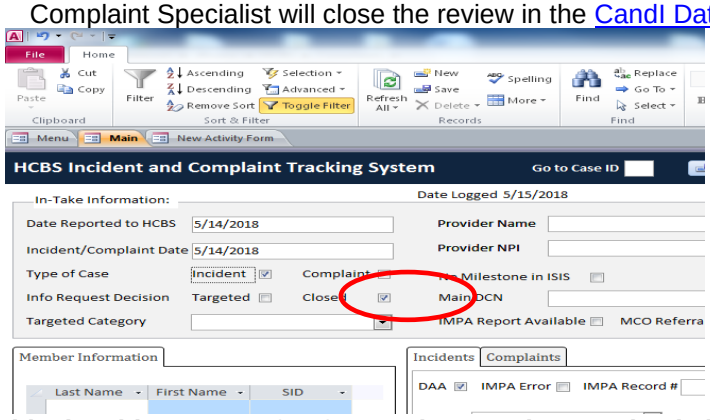
Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required

then the letter titled *Complaint Review_NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.

- Information not received within 15 business days will require the letter titled *Complaint Req Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP.
- If CAP information is not received within 30 business days, then the letter titled *CAP Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested CAP information.
- Once the CAP information is received and reviewed, the HCBS Specialist has 15 business days to accept or deny the CAP. If the CAP is accepted then the letter titled CAP Review Accepted will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.
- If the CAP information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *CAP Review Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit acceptable CAP.
- A compliance review will be initiated with 45 business days of the CAP being accepted. The letter titled *Compliance Review Initiation* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 15 business days to submit requested compliance material.
- If compliance material is not received within 15 business days, then the letter titled *Compliance Review Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested compliance material.
- The HCBS Incident and Complaint Specialist has 15 business days to review information and determine if a compliance is accepted. Once the compliance information is accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The targeted review will be closed.
- If the compliance information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit compliance material.
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the CandI Database.



Critical Incident report fee-for service member received via email

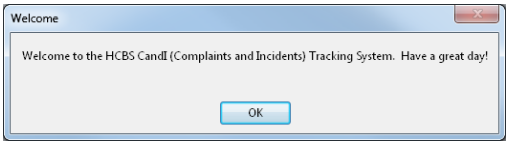
Incident reports will not be accepted via email. If an incident report is submitted via email, the HCBS Incident and Complaint Specialist will use ISIS and MMIS to determine if the member is FFS or enrolled with a Managed Care Organization (MCO). If the member is FFS then the HCBS Incident and Complaint Specialist will reply to the sender with the following information:

Critical incident reports can only be accepted via IMPA. This incident has not been uploaded to IMPA and has not been accepted. Please verify you are using the form directly from within the IMPA website, at the bottom left side of the home page. That is the only version of the form that is formatted for upload. Once you have completed the correct form, upload directly to IMPA by logging in and selecting "File-> Upload File -> Critical Incident Report". Please reference IL 1814 for additional information. If you are having issues submitting this through IMPA then you will need to work with Provider Services 1-800-338-7909 or IMPA support impasupport@dhs.state.ia.us.

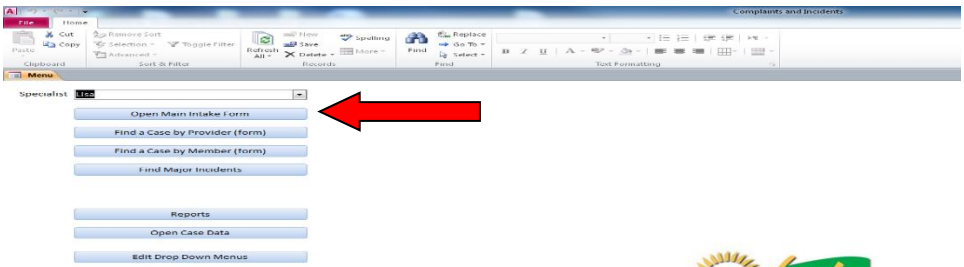
The HCBS Incident and Complaint Specialist will then log as technical assistance (TA) into QPS.

- If follow-up is not required then the HCBS Incident and Complaint Specialist will document the information on the Master List spreadsheet and follow-up as indicated on the spreadsheet. The HCBS Incident and Complaint Specialist will check IMPA on a weekly basis to ensure that Critical Incident Report has been properly received. If the incident report is not received, then the HCBS Incident and Complaint Specialist will work with the reporting party to assist with this process.

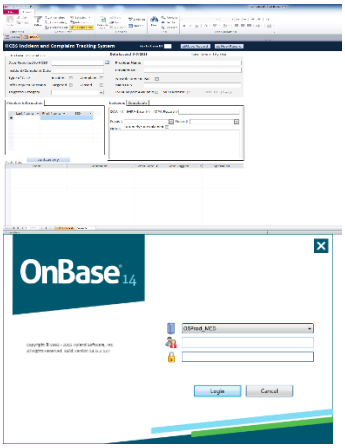
- The HCBS Incident and Complaint Specialist will determine if immediate follow-up is required enter the information into the CandI Database
    - *Reasons for Follow-Up (not an exclusive list)*
        - *Death (ALL deaths require follow-up)*
        - *Medication Error*
        - *Lack of supervision and no resolution defined on report*
        - *Member service plan was not followed (i.e. restraints, rights restrictions, supervision, etc)*
        - *Abuse/Injury and no explanation or resolution defined on report*
- Additional information requested from the Case Manager or the Provider that may require further investigation will require the HCBS Incident and Complaint Specialist to create the *Complaint Req Info*. Enter the information into the CandI Database. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.



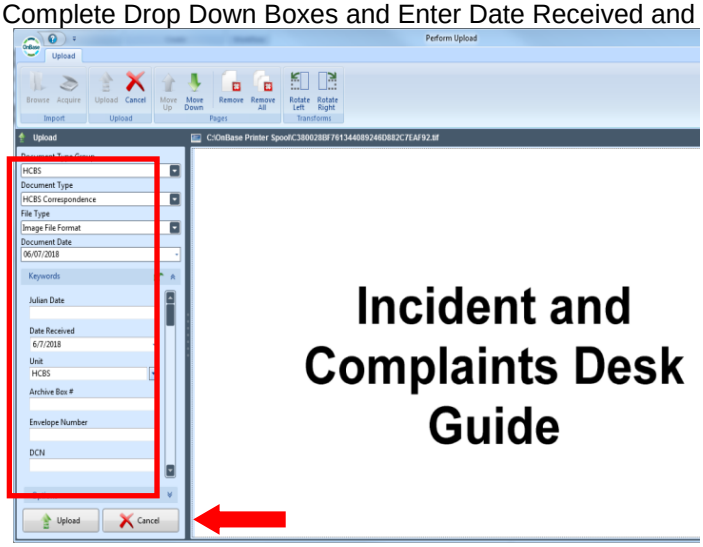
Click “Open Main Intake Form” to create a new case



Enter information into all applicable fields that apply to the case being reviewed

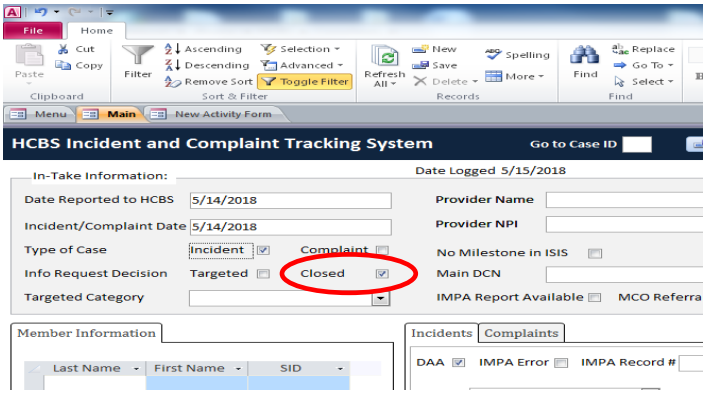


Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required then the letter titled *Complaint Review_NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.
- Information not received within 15 business days will require the letter titled *Complaint Reg Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP.
- If CAP information is not received within 30 business days, then the letter titled *CAP Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested CAP information.
- Once the CAP information is received and reviewed, the HCBS Specialist has 15 business days to accept or deny the CAP. If the CAP is accepted then the letter titled CAP Review Accepted will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.
- If the CAP information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *CAP Review Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit acceptable CAP.

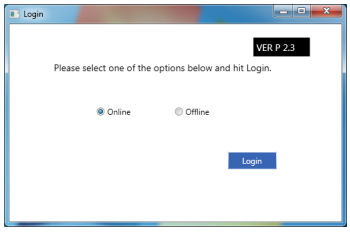
- A compliance review will be initiated with 45 business days of the CAP being accepted. The letter titled *Compliance Review Initiation* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 15 business days to submit requested compliance material.
- If compliance material is not received within 15 business days, then the letter titled *Compliance Review Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested compliance material.
- The HCBS Incident and Complaint Specialist has 15 business days to review information and determine if a compliance is accepted. Once the compliance information is accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The targeted review will be closed.
- If the compliance information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit compliance material.
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the CandI Database.



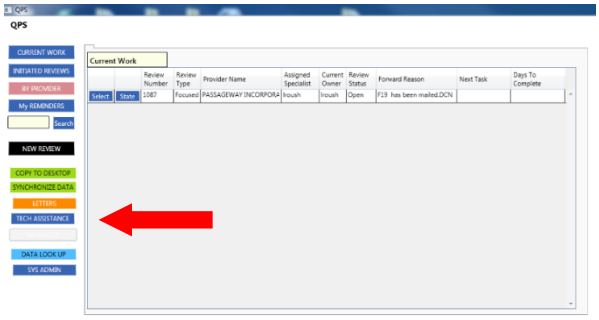
Critical Incident Report FFS member received via onbase

- If a Critical Incident Report is received via Onbase, the HCBS Incident and Complaint Specialist will use ISIS and/or MMIS to determine if the member is enrolled as a fee-for-service (FFS) member or enrolled with a Managed Care Organization (MCO).
- If member is FFS and a Critical Incident report is received via Onbase, the HCBS Incident and Complaint Specialist will reply to the email with the following statement,

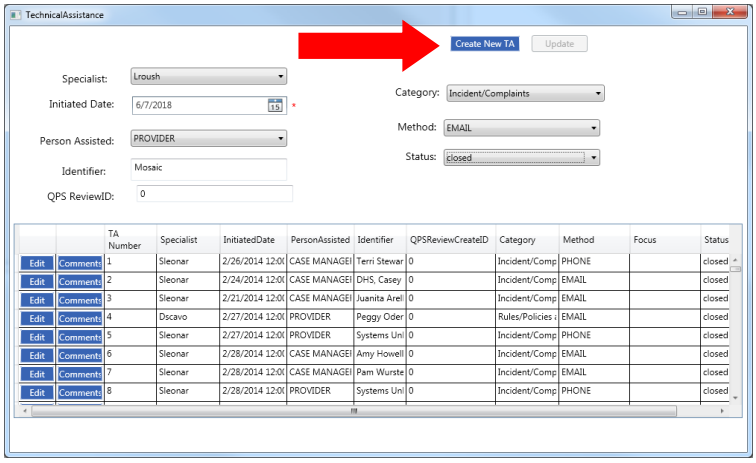
  A critical incident report was received in the IME's electronic queue. This incident has not been uploaded to IMPA and has not been accepted. Please verify you are using the form directly from within the IMPA website, at the bottom left side of the home page. That is the only version of the form that is formatted for upload. Once you have completed the correct form, upload directly to IMPA by logging in and selecting "File-> Upload File -> Critical Incident Report". Please reference IL 1814 for additional information. If you are having issues submitting this through IMPA then you will need to work with Provider Services 1-800-338-7909 or IMPA support impasupport@dhs.state.ia.us. Critical incident reports can only be accepted via IMPA.
- A note in Onbase will be placed on the incident report stating that an email was sent to the reporting party and TA was provided on how to properly submit the incident report and then the incident report will be "completed" in Onbase.
- The HCBS Incident and Complaint Specialist will then log a technical assistance (TA) into QPS.
  Open QPS



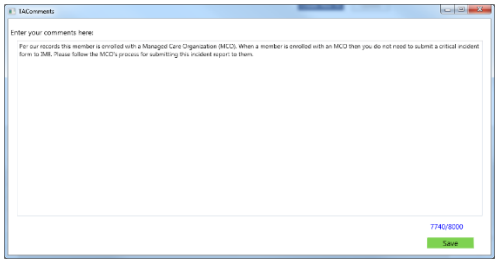
Click - Tech Assistance



Complete all of the drop down boxes and click Create New TA



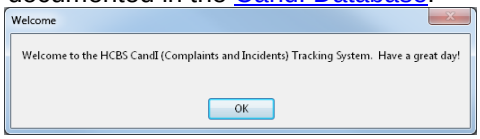
Enter Comments and Click Save



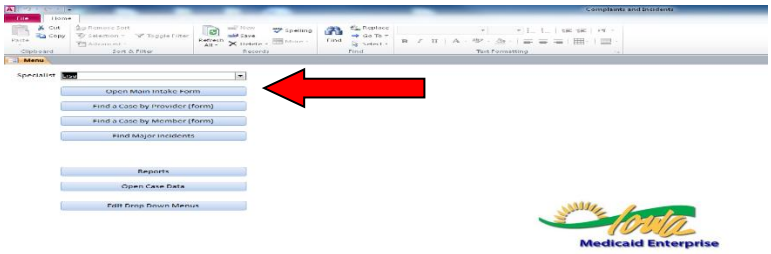
- If follow-up is not required then the HCBS Incident and Complaint Specialist will document the information on a master List spreadsheet and follow-up as indicated on the spreadsheet. The HCBS Incident and Complaint Specialist will check IMPA on a weekly basis to ensure that Critical Incident Report has been properly received. If the incident report is not received, then the HCBS Incident and Complaint Specialist will work with the reporting party to assist with this process.
- The HCBS Incident and Complaint Specialist will determine if immediate follow-up is required enter the information into the CandI Database

  Reasons for Follow-Up (not an exclusive list)
  - *Death (ALL deaths require follow-up)*
  - *Medication Error*
  - *Lack of supervision and no resolution defined on report*
  - *Member service plan was not followed (i.e. restraints, rights restrictions, supervision, etc)*
  - *Abuse/Injury and no explanation or resolution defined on report*

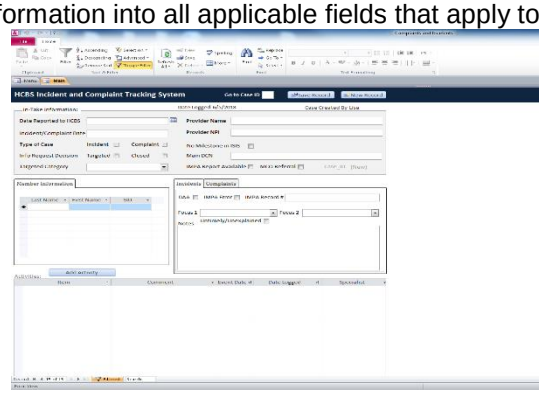
- Additional information requested from the Case Manager or the Provider that may require further investigation will require the HCBS Incident and Complaint Specialist to create the *Complaint Req Info* Letter. Enter the information into the CandI Database found here. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.

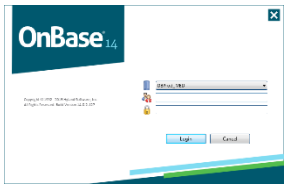


- Click “Open Main Intake Form” to create a new case

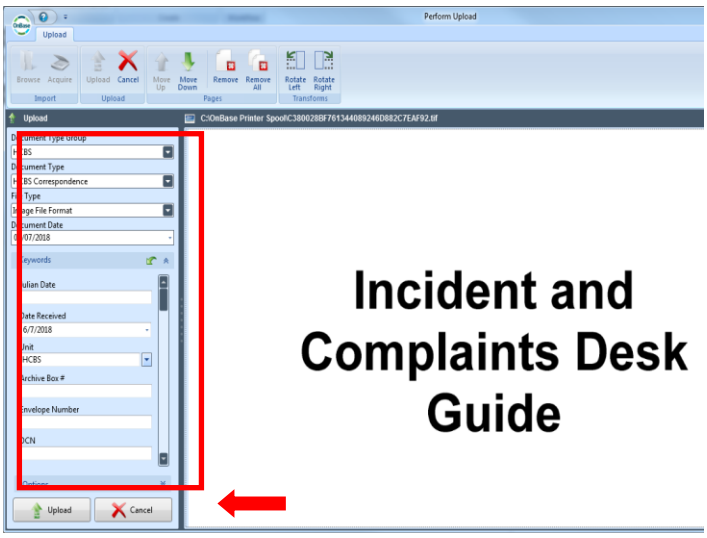


Enter information into all applicable fields that apply to the case being reviewed

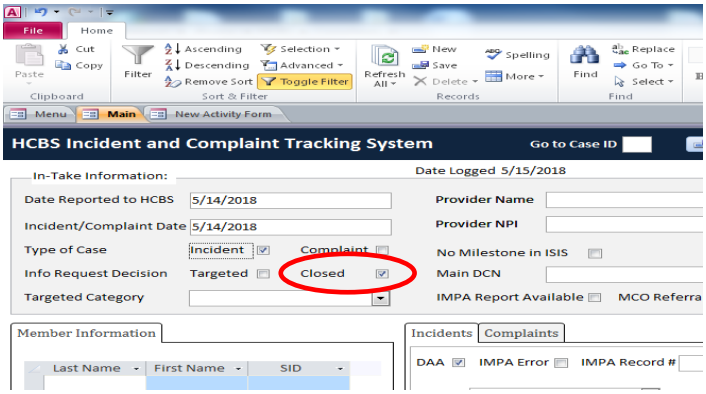




Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required then the letter titled *Complaint Review NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.
- Information not received within 15 business days will require the letter titled *Complaint Req Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP.
- If CAP information is not received within 30 business days, then the letter titled *CAP Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested CAP information.
- Once the CAP information is received and reviewed, the HCBS Specialist has 15 business days to accept or deny the CAP. If the CAP is accepted then the letter titled CAP Review Accepted will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.
- If the CAP information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *CAP Review Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit acceptable CAP.
- A compliance review will be initiated with 45 business days of the CAP being accepted. The letter titled *Compliance Review Initiation* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 15 business days to submit requested compliance material.
- If compliance material is not received within 15 business days, then the letter titled *Compliance Review Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested compliance material.
- The HCBS Incident and Complaint Specialist has 15 business days to review information and determine if a compliance is accepted. Once the compliance information is accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The targeted review will be closed.
- If the compliance information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit compliance material.
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the CandI Database.



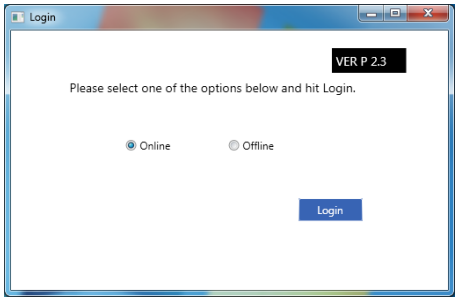
<u>Critical Incident Report Received For Managed Care Organization (MCO) Member via Email</u>

Incident reports will not be accepted via email. If an incident report is submitted via email, the HCBS Incident and Complaint Specialist will use ISIS and/or MMIS to determine if the member is enrolled with an MCO. If the member is MCO then the HCBS Incident and Complaint Specialist will reply to the sender with the following information:

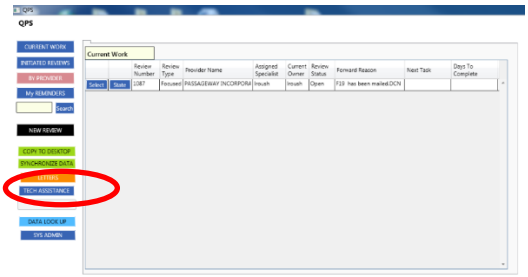
> Per our records this member is enrolled with a Managed Care Organization (MCO). When a member is enrolled with an MCO then you do not need to submit a critical incident form to IME. Please follow the MCO's process for submitting this incident report to them.

The email will be deleted and the HCBS Incident and Complaint Specialist will then log a technical assistance (TA) into QPS.

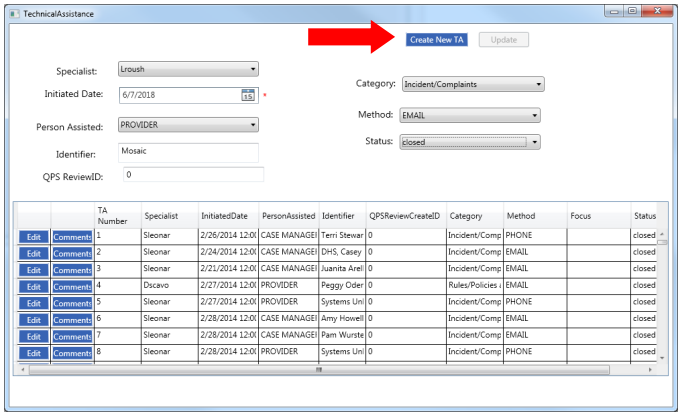
Open QPS



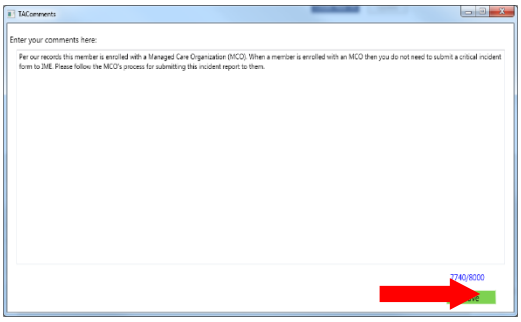
Click - <u>Tech Assistance</u>



Complete all of the drop down boxes and click <u>Create New TA</u>



Enter Comments and Click Save



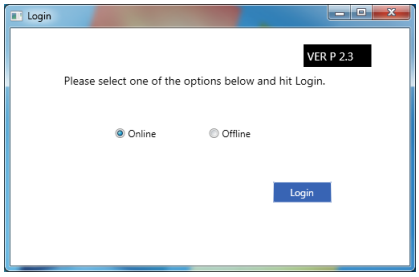
Critical Incident Report Received for MCO member via Onbase

If a Critical Incident Report is received via Onbase, the HCBS Incident and Complaint Specialist will use ISIS and/or MMIS to determine if the member is enrolled as a fee-for-service (FFS) member or enrolled with a Managed Care Organization (MCO).

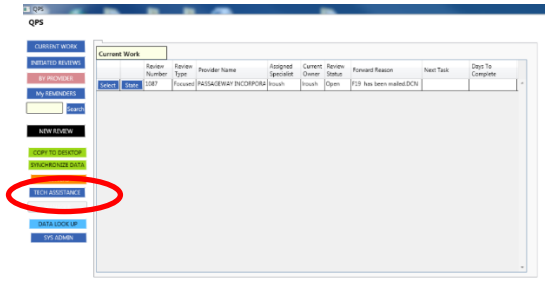
If the member is enrolled with an MCO, the HCBS Incident and Complaint Specialist will reply to the sender of the email the following statement,

> A critical incident report was received in the IME's electronic queue. Per our records, the member is enrolled with a Managed Care Organization (MCO). When a member is enrolled with an MCO then you do not need to submit a critical incident form to IME. Please follow the MCO's process for submitting this incident report to them.

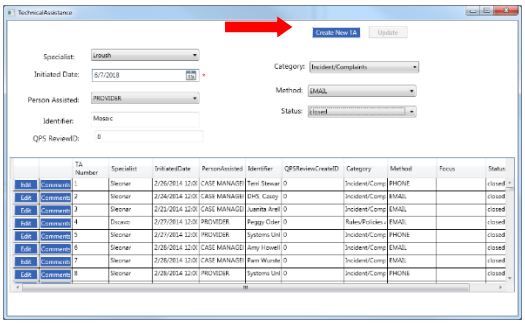
A note in Onbase will be placed on the incident report stating that the member is enrolled with an MCO and then the incident report will be "completed" in Onbase.
The HCBS Incident and Complaint Specialist will then log a technical assistance (TA) into QPS.
Open QPS



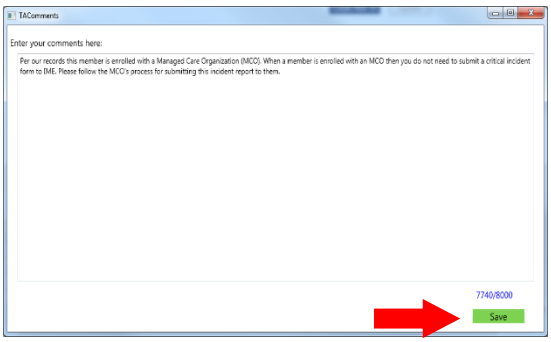
Click - Tech Assistance



Complete all of the drop down boxes and click Create New TA



Enter Comments and Click Save

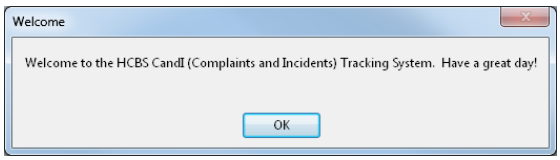


Complaints

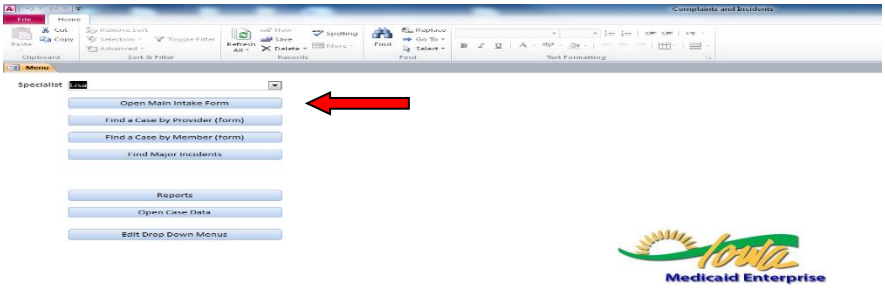
A complaint can be received by any person who has a concern and can be received via email, fax, telephone, or in person.

When a compliant is received, the person who is obtaining the information should ensure that all of the information required for the Complaint Intake Form is obtained.

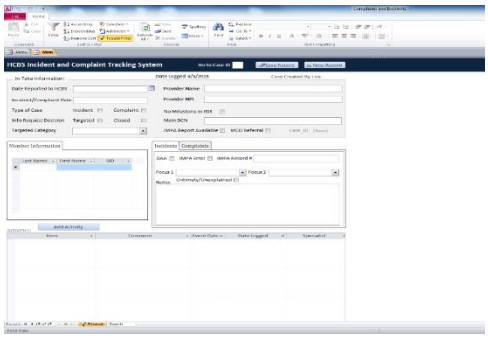
The information will be entered into the CandI Databse and the Complaint Intake Form will be uploaded into Onbase.

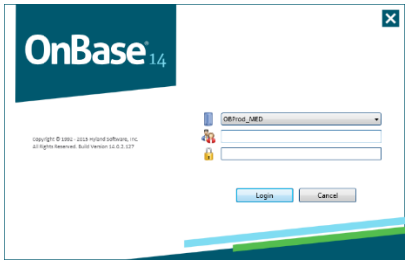


Click “Open Main Intake Form” to create a new case

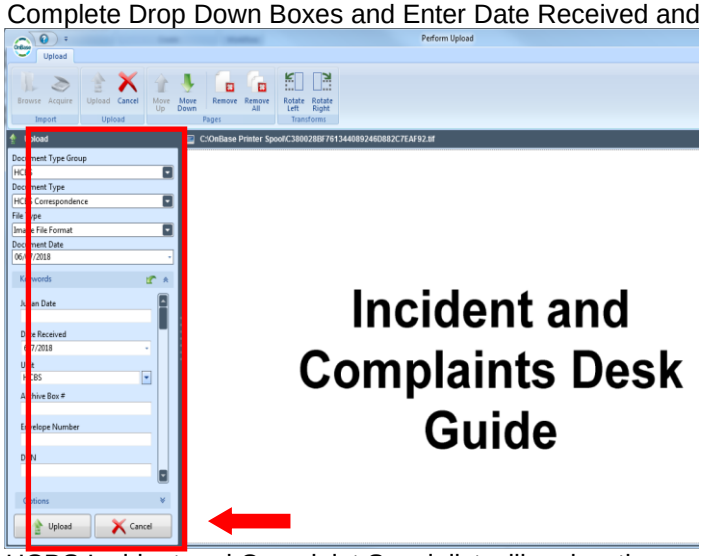


Enter information into all applicable fields that apply to the case being reviewed





Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



The HCBS Incident and Complaint Specialist will review the complaint and determine if follow-up is required.

Reasons for Follow-Up (not an exclusive list)

- *Complaint against a provider*
  - *Rights Restrictions*
  - *Improper discharge*
  - *Abuse/Neglect*

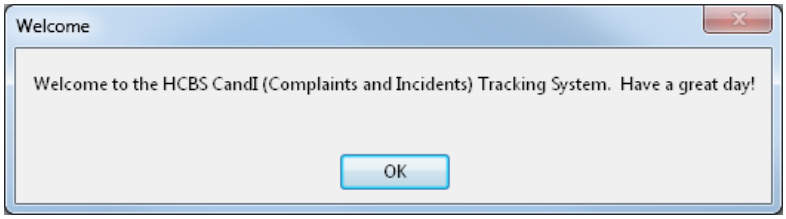
- *Member Rights*
- *Complaint against a member*

If the complaint involves a potential dependent adult abuse (DAA) investigation then the complainant will be provided the information necessary to properly report the abuse. If the complainant is not able to submit the information then the HCBS Incident and Complaint Specialist will report the potential abuse to the Child and Dependent Adult Abuse Hotline at 1-800-362-2178.

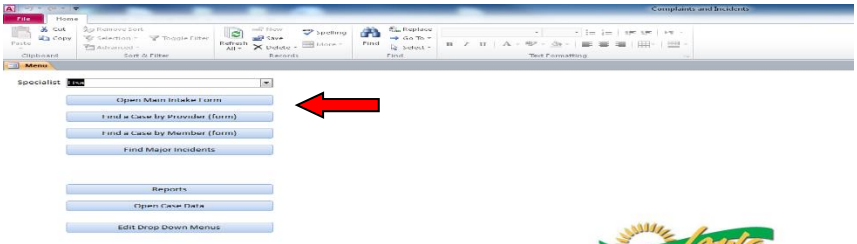
Depending on the severity and type of complaint, the HCBS Incident and Complaint Specialist may recommend that the complainant file a grievance if they have not already done so.

If a grievance has been filed with no results or the complaint requires further investigation from HCBS Quality Assurance Unit then the HCBS Incident and Complaint Specialist will initiate a request for additional information from the provider.

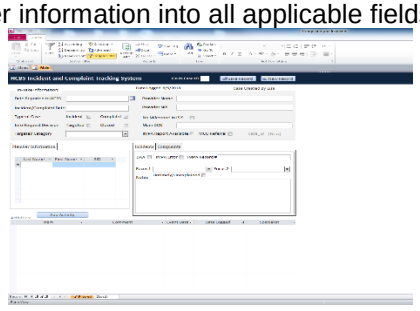
- The HCBS Incident and Complaint Specialist will create the *Complaint Req Info* Letter. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.

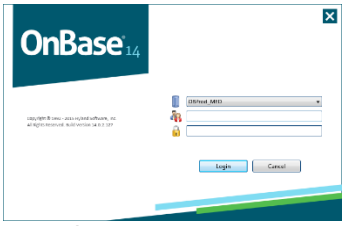


Click “Open Main Intake Form” to create a new case



Enter information into all applicable fields that apply to the case being reviewed

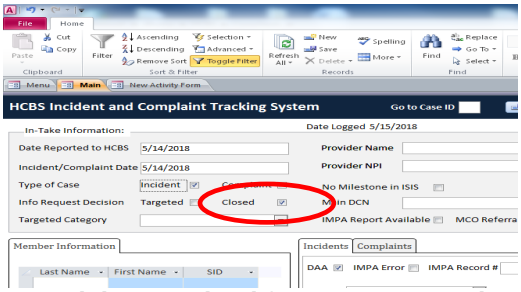




Complete Drop Down Boxes and Enter Date Received and Unit Click Upload

- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required then the letter titled *Complaint Review_NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.
- Information not received within 15 business days will require the letter titled *Complaint Req Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP.
- If CAP information is not received within 30 business days, then the letter titled *CAP Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested CAP information.
- Once the CAP information is received and reviewed, the HCBS Specialist has 15 business days to accept or deny the CAP. If the CAP is accepted then the letter titled CAP Review Accepted will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.
- If the CAP information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit acceptable CAP.
- A compliance review will be initiated with 45 business days of the CAP being accepted. The letter titled *Compliance Review Initiation* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 15 business days to submit requested compliance material.
- If compliance material is not received within 15 business days, then the letter titled *Compliance Review Not Received* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit the requested compliance material.
- The HCBS Incident and Complaint Specialist has 15 business days to review information and determine if a compliance is accepted. Once the compliance information is accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The targeted review will be closed.

- If the compliance information is not accepted by the HCBS Incident and Complaint Specialist then the letter titled *Compliance Review Results Not Accepted* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 10 business days to submit compliance material.
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the CandI Database.

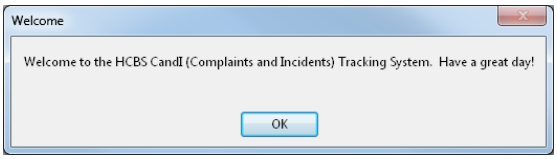


Complaint Received for an MCO member

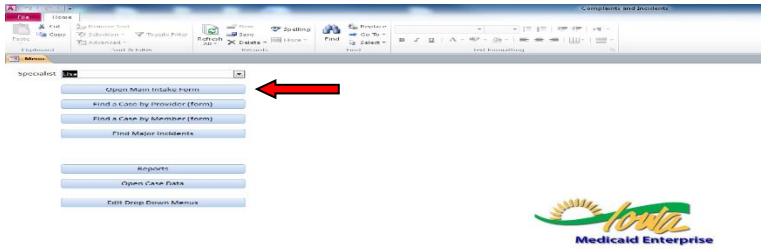
When a complaint is received the HCBS Incident and Complaint Specialist will use ISIS and/or MMIS to determine if the member is enrolled as a fee-for-service (FFS) member or enrolled with a Managed Care Organization (MCO).

- If the member is enrolled with an MCO, the HCBS Incident and Complaint Specialist will gather all of the required information and complete the Complaint Intake Form. Enter the information into the CandI Database. Upload the complaint form into Onbase, add a note indicating that the member is enrolled with an MCO, the date that the form was emailed, and complete it.
- The complaint form will be sent via email to the member's MCO.
  - Amerigroup- IAincidents@amerigroup.com
  - Iowa Total Care- QOCCIR@Iowatotalcare.com

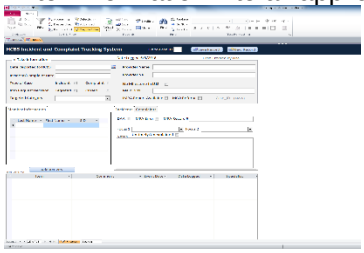
In the CandI Database, the HCBS Incident and Complaint Specialist will check the boxes, "MCO Referral" and "Closed".

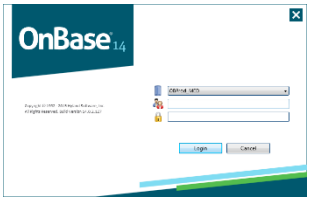


Click "Open Main Intake Form" to create a new case

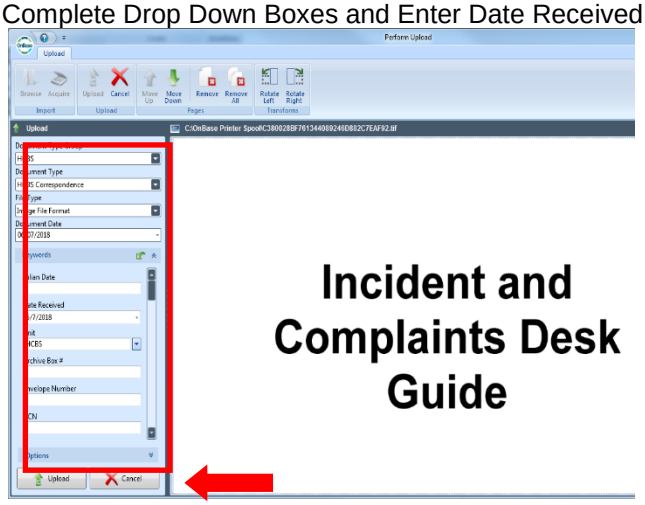


Enter information into all applicable fields that apply to the case being reviewed





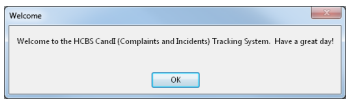
Complete Drop Down Boxes and Enter Date Received and Unit Click Upload

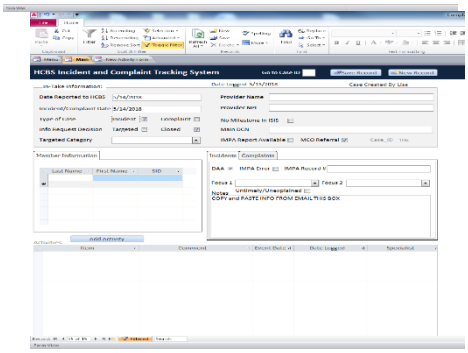


Dependent Adult Abuse Report

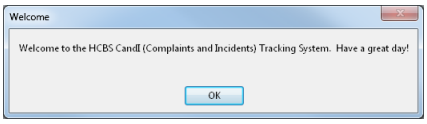
When dependent adult abuse (DAA) information is received the HCBS Incident and Complaint Specialist will use ISIS and/or MMIS to determine if the member is fee-for-service (FFS) or enrolled with a Managed Care Organization (MCO). The HCBS Incident and Complaint Specialist will review the information and determine if the report requires further follow-up.

If follow-up is not required, the HCBS Incident and Complaint Specialist will enter the information to the CandI Database and enter a reason why no follow-up was completed and close the review.

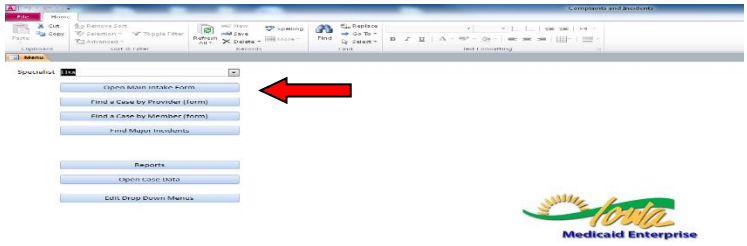




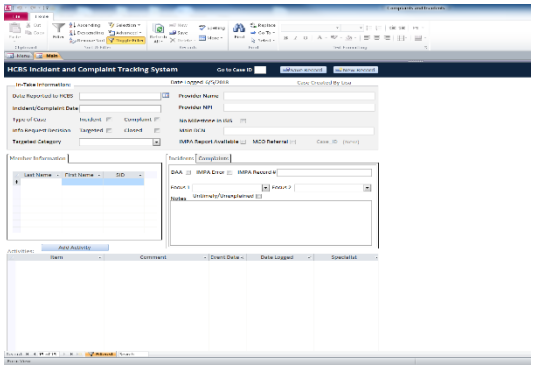
- If the DAA does require follow-up, the HCBS Incident and Complaint Specialist will enter the initial information in to the CandI Database and contact the DAA investigator for additional details.
- ..... The additional information will be documented in to the CandI Database.
- ..... The HCBS Incident and Complaint Specialist will use ISIS to identify the member's service(s), providers, and case manager.
- ..... If applicable, the HCBS Incident and Complaint Specialist will utilize IMPA to identify if a Critical Incident Report was completed.
- ..... If applicable and a Critical Incident Report was not completed, then the HCBS Incident and Complaint Specialist will contact the member's case manager to request that the Critical Incident Report be completed.
- ..... If applicable, and a Critical Incident Report was completed, then the HCBS Incident and Complaint Specialist will determine if follow-up is required.
- Additional information requested from the Case Manager or the Provider that may require further investigation will require the HCBS Incident and Complaint Specialist to create the *Complaint Req Info Letter*. Enter the information into the CandI Database. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database.

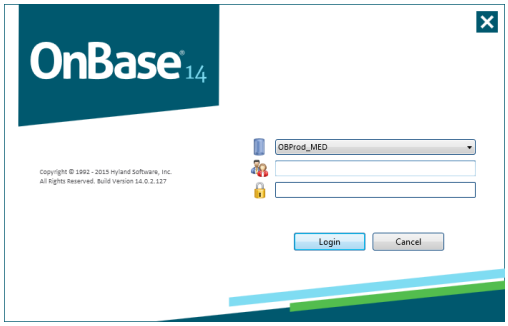


Click "Open Main Intake Form" to create a new case

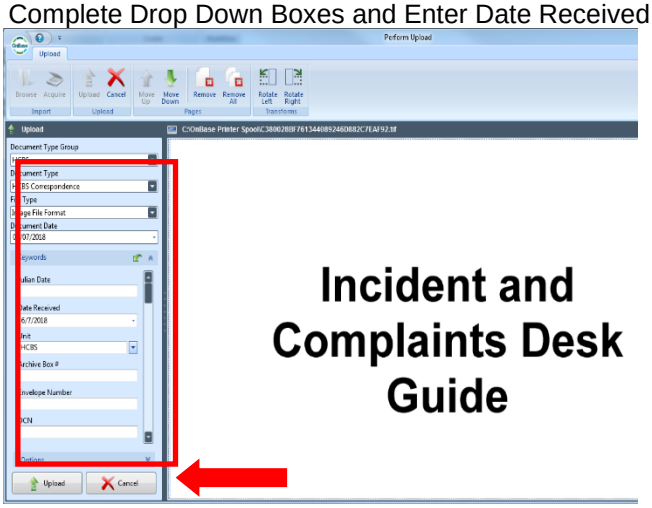


Enter information into all applicable fields that apply to the case being reviewed





Complete Drop Down Boxes and Enter Date Received and Unit Click Upload



- The agency has 15 business days to return the information. Once the information is received, the HCBS Incident and Complaint Specialist has 30 business days to determine if a corrective action plan (CAP) is required. If the HCBS Incident and Complaint Specialist does not feel that a targeted review is required then the letter titled *Complaint Review NO Further Action Required* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The review will be closed.
- Information not received within 15 business days will require the letter titled *Complaint Req Info Not Received*. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider will have 5 business days to submit the requested information.
- The HCBS Incident and Complaint Specialist has 30 business days to determine if a targeted review with a CAP is required. If yes, then the letter titled *Targeted Review with CAP* will be completed. The letter will be reviewed and approved by the Operations Manager, emailed to the Case Manager or Provider, uploaded into Onbase, and documented in the CandI Database. The provider has 30 business days to submit a CAP.
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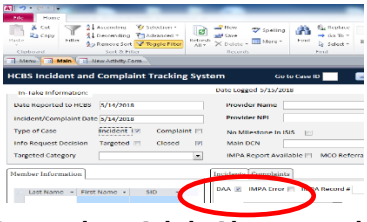
- When the process of reviewing the Incident is complete and satisfactory then HCBS Incident and Complaint Specialist will close the review in the CandI Database.



Dependent Adult Abuse received for an MCO member

When dependent adult abuse (DAA) information is received, the HCBS Incident and Complaint Specialist will utilize MMIS to identify which Managed Care Organization (MCO) the member is enrolled with.

The HCBS Incident and Complaint Specialist will complete the following fields in the CandI database

- Date Reported to HCBS
- Incident/Complaint Date
- Member Last Name, First Name, SID

Information received regarding the member and the situation will be entered into the “Notes” section of CandI.

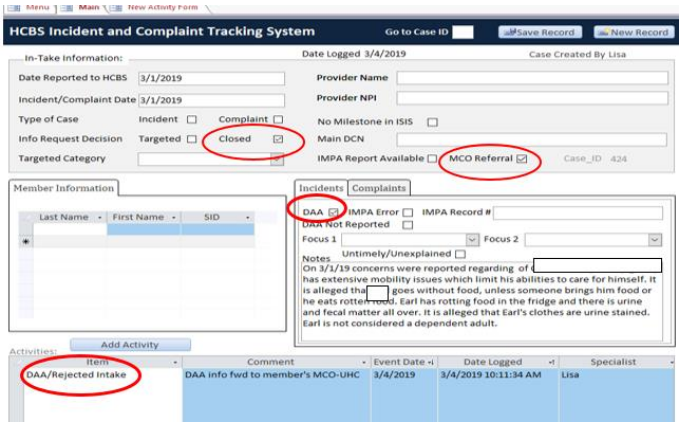
An email with all of the information will be emailed to the corresponding MCO

- Amerigroup- IAincidents@amerigroup.com
- Iowa Total Care- QOCCIR@Iowatotalcare.com

Once the information has been entered into CandI and emailed to the MCO, a note will be entered in CandI under “Add Activity” using the “DAA/Rejected Intake” activity.

The following statement will be entered- “DAA info was forwarded to member’s MCO-(enter the MCO)” UHC, AG, or ITC

Check boxes for DAA, MCO Referral, and Closed will be marked

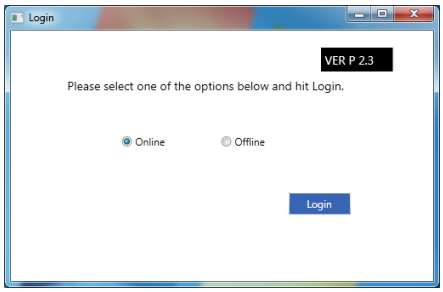


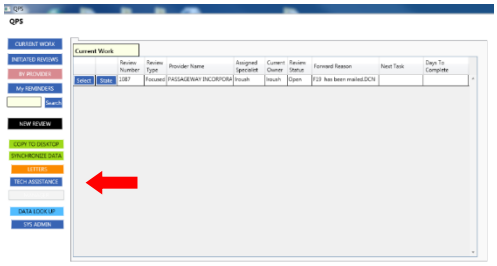
Incident and Complaints Mailbox

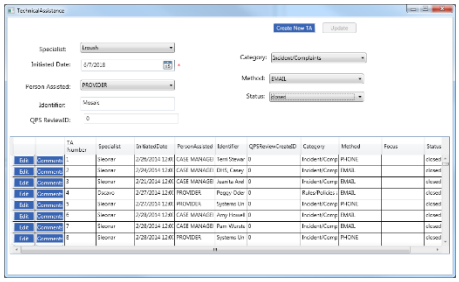
The HCBS Incident and Complaint Specialist will monitor the Incident and Complaint Mailbox (IR mailbox) on a daily basis several times throughout the day and reply to emails within 24-hours.

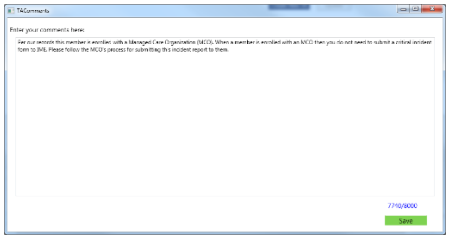
Common emails received in the IR mailbox are questions regarding how to use IMPA for Critical Incident Reports, improperly submitted Critical Incident Reports, questions regarding reporting of incidents, Dependent Adult Abuse (DAA) rejected intakes, or any other questions that requires technical assistance.

Technical assistance will be documented in QPS.









Quality Assurance Frequency
Annual

Change History

Change Date:	Changed by:	Description:	New Version Number:	Last Reviewed Date:
August 1, 2019	Shannon Miller	Updated	2	August 1, 2019

Signature
Shannon Miller, MPA August 1, 2019