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 settings that cannot come into compliance, the state must establish a process for the timely transition of members into 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.

With this final draft version of the Statewide Transition Plan (STP) a few changes to the content of the plan should be noted:

- All references to the Iowa Medicaid Enterprise (IME) have been changed and are now referenced as Iowa Medicaid
- The HCBS Quality Improvement Organization (HCBS QIO) is now referenced as the QIO HCBS Unit
- Programs that fall within the scope of the STP are referenced as HCBS waiver and Habilitation programs
- For ease of reading, sections of the previous approved STP have been moved within this version to consolidate and group together information. When moved, the reader will see a section heading identified as “updated explanation”. All consolidated content will be *italicized* following the heading.
- New content will be noted as “new section”. All content will be *italicized* following the heading.

II. HCBS in Iowa

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 (1915(i) – 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. However, the program provides the type of services typically needed by adults with a chronic mental illness.

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 Intermediate Care Facility for Individuals

with Intellectual Disability (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 disturbance who meet the level of care provided in a psychiatric hospital serving children under the age of 21. 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 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 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.

III. Overview of the Federal HCBS Settings Rule

The final settings rule requires that all HCBS settings be integrated in and 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. 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 settings 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 makes distinctions between settings where HCBS services may be provided. Included are:

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

A. 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

B. Settings 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 Quality Improvement Organization HCBS (QIO HCBS) 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, including 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, to receive continued HCBS funding in that setting.

C. Settings that could be compliant with the final rule with some modifications

Some residential or non-residential settings 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 QIO HCBS Unit and reviewed for compliance with the rules. Providers that have 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, 2023, to receive HCBS funding in service setting.

D. Settings 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

E. 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 member 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 member to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.
- Each member 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 member with only appropriate staff having keys; members having a choice of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.
- Members 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.

IV. Iowa's Statewide Transition Plan History

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:

1. 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.
2. 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.
3. 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.
4. 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 the CMS deadline which is now March 17, 2023.
5. 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.

A complete initial STP was submitted to CMS addressing the issues identified above after internal review by Iowa Medicaid and the STP stakeholder committee, and after incorporation of public comments. The completed, initial STP was approved by CMS on August 9, 2016. Iowa published a final STP on December 19, 2019, to which CMS responded with additional guidance for fully implementing the plan. To receive final approval for Iowa's STP, Iowa must address the additional questions and feedback outlined below.

1. Clarify if residential assessments addressed all HCBS settings criteria, who completes the residential assessments for each of the delivery systems, verify residential assessments are completed without conflict of interest, and clarify the

response validation process. Explain in detail the self-assessment process including a description of the methodology for “calculating the scores of the self-assessments”, the process for validating responses, and an explanation of how providers not required to submit an annual self-assessment are monitored for compliance with HCBS settings requirements.

2. Clarify the IPES process including whether IPES are completed for both residential and non-residential settings, sampling for the IPES participants, and how responses are tied back to individual settings and the follow-up process for “flagged” responses. Additionally, Iowa is asked to clarify a discrepancy in the number of IPES Explain how the regular review processes, residential assessment process, provider self-assessment process, and IPES responses work together.
3. Clarify the remediation process, also known as “modifications”, corrective action plan (CAP) requirement, or “CAP and compliance”. Specifically, provide details about how Iowa identified settings that comply with HCBS settings requirements after remediation. Provide detailed timelines and milestones for the remediation process that demonstrates that the provider has enough time for the state to verify remediation has occurred prior to March 17, 2023.
4. Explain how specific types of settings are monitored including private homes, settings in which an individual lives with an unrelated caregiver providing HCBS services, and community locations where supported employment is provided.
5. Regarding employment services, detail the specific number of non-residential supported employment and prevocational settings within the state and, if possible, specify between individual and group supported employment placements.
6. Clarify charts and information in the initial STP regarding how many and what types of settings may become compliant with remediation, how many and what types of settings cannot become compliant.
7. Describe how the state will identify settings (both residential and non-residential) that may have the effect of isolating individuals.
8. Clarify how the state is identifying sites it may present for heightened scrutiny, when it expects to have identified those sites, and when the state expects to put forth evidence for heightened scrutiny review to CMS. It is also recommended by CMS to submit settings for heightened scrutiny review on a rolling basis and to ensure sufficient time for additional remediation or communication processes to be completed by compliance deadline.
9. Clarify and update the list of settings (12) previously identified by the state as potential referrals for heightened scrutiny review.
10. Clarify the process by which the state will verify remediation has occurred in those 12 settings prior to the compliance deadline.

11. Provide a detailed description of the state's transition process for settings that cannot come into compliance by the compliance deadline including a description of how members are given notice with associated timeframes, how the state will offer informed choice of alternative settings through person-centered planning, who is responsible for executing the planning and the process, and a description of how the state will ensure that all critical services and supports are in place in advance of each member's transition.
12. Clarify how many individuals have been relocated to date for the settings that do not and will not comply, and an estimate of the number of members that may be in non-compliant settings.
13. Include a timeline for identification of the settings, notification allowing for ample time for due process and relocation deadlines.
14. Explain what the state of Iowa is doing to build capacity of non-disability specific settings in the state.
15. Add a key to service abbreviations.
16. Ensure all materials are compliant with Section 508 standards.
17. Explain the impact of the COVID-19 public health emergency on the assessment and review process.

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 revise the plan, as appropriate, before the plan is considered final.

A. Public Notice and Comment Period

NOTE: This section will be completed by Iowa Medicaid after the public comment period ends for this version of the Statewide Transition Plan. The final version of the STP, including public comments and the Iowa Medicaid response, will be posted to the Iowa Medicaid webpage found HERE. The final STP version, with comments and responses will be sent to CMS.

A public notice was published electronically on June 3, 2022 on the Iowa Medicaid 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 member services publication sent to all Medicaid recipients. This publication was sent on June 3, 2022. Notice was sent to the federally recognized tribes on June 3, 2022. Social Media notice was published via Iowa Medicaid's Facebook platform (IA Health Link) on June 3, 2022.

The current final statewide transition plan was posted on the Iowa Medicaid website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The final transition plan posted for public comment on June 3, 2022 was revised to address CMS comments described in Section V., Iowa Statewide Transition Plan History, above. This information was added to the currently posted transition plan. The revised plan was available from June 3, 2022 and comments were received through July 5, 2022. The revised transition plan was made available for non-electronic viewing in all the DHS county offices across the state for persons who may not have internet access. Comments were received at the local DHS offices from June 3, 2022 through July 5, 2022.

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 Iowa Medicaid by mail or by delivering them directly to the Iowa Medicaid office.

The following are the comments received and the IME's response to each. Changes were made to the final STP based on comments received. Changes made to this version of the STP are *italicized*.

VI. Iowa's Systemic Assessment Process

In response to CMS feedback and public comment, Iowa Medicaid has taken a multifaceted approach to the identification, review, assessment, and evaluation of all residential and non-residential settings where HCBS waiver and Habilitation services are provided for the purpose of assuring all settings meet state and federal rules and regulations. This section explains each process and how it was used for initial discovery of HCBS settings across Iowa and, if applicable, how it has been used ongoing for continued discovery, remediation, and improvement of HCBS settings. Plans for updates and enhancements to these processes are also described in this section. See Section VIII. for an analysis of results of these processes to date.

These processes include:

- Annual provider self-assessment, address collection, and attestation (form #470-4547)
- Geo-mapping technology
- Quality oversight and review including review of residential and non-residential settings by the Quality Improvement Organization (QIO) HCBS Unit
- Residential assessments completed by each member's community-based case manager
- Use of Iowa Participant Experience Survey (IPES) results for member experiences
- Administrative rules review and changes

A. Annual Provider Self-Assessment

Iowa Medicaid maintains a contract for the QIO HCBS Unit through a request for proposal process. The QIO HCBS Unit is the single entity responsible for all quality oversight activities for the HCBS waiver 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 QIO HCBS Unit is responsible for coordinating quality assurance activities and reporting to Iowa Medicaid. Currently Iowa Medicaid contracts with Telligen, Inc. to conduct the quality oversight activities of the HCBS waiver and Habilitation programs.

Updated explanation:
The QIO HCBS Unit uses the HCBS Provider Quality Management Self-Assessment (SA) tool (Attachment A form #470-4547) as the foundation for all quality assurance activities. All HCBS waiver and Habilitation providers that are subject to the HCBS settings standards must complete an SA at enrollment and annually. The SA is a multifunctional tool that encompasses a checklist for providers to follow in assessing their own compliance with HCBS settings standards and all applicable requirements pursuant to the Code of Federal Regulations (CFR), Iowa Code (IC), Iowa Administrative Code (IAC)and other standards and best practices.

The checklist portion of the SA includes questions about policies, procedures, and systems the provider has in place for meeting settings requirements in all environments where they provide HCBS waiver or Habilitation services. Providers indicating "No" to meeting a standard must also provide a CAP with a timeline and an explanation of how they will come into compliance. The provider's QIO HCBS Specialist reviews each

submission for completeness and accuracy. Discrepancies and inadequate CAP are resolved prior to acceptance of the provider's annual SA. Successful implementation of identified CAP are reviewed with the next annual self-assessment or through a regular review process, whichever comes first.

Requirements specific to HCBS settings rules were added to the SA beginning in 2014. In 2018, the settings requirement section was refined to separate requirements for provider owned and controlled residential settings from general settings requirements (see Requirement B sections 7 – 14 of Attachment A). 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 or the financial conditions applicable to the member. The unit or dwelling must be 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, there must be a lease, residency agreement or other form of written agreement in place for each HCBS member. The document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

The SA also serves as an annual provider attestation whereby the provider certifies that the information and responses on the self-assessment are true, accurate, complete, and verifiable. The responses are verified through the regular and ongoing quality oversight reviews conducted by the QIO HCBS Unit. The QIO HCBS Specialist reviews the SA responses and compares to the provider's written policies and procedures and specific evidence found through review of member and personnel records, service documentation, residential assessments for selected members, onsite tours, and incident and complaint information. A CAP is required if it is found that a provider's responses on the SA are not in line with policies, procedures, and evidence found during a review. See section VI. C. Quality Oversight Reviews, for more specific information about the regular quality oversight reviews conducted by the QIO HCBS Unit.

Lastly, beginning with the 2016 SA, the SA process includes an "address collection tool" for providers to list specific locations where they provide non-residential and residential services in provider-owned or controlled settings. Prior to the address collection tool, other means of collecting information about specific service sites were tried. The address collection tool is a key component of the geo-mapping technology outlined in

section VI. B. Geo-mapping and in the ongoing discovery of settings that may require heightened scrutiny.

The SA tool, including the address collection tool is slated to be updated for implementation in the next self-assessment cycle which begins in late 2022. The updates include enhancements to the section related to the HCBS settings final rule which will allow providers to self-assess for compliance with settings requirements at the provider/service level, individual location/ site level, and based on individual member experiences. The updated version of the 2022 SA will be available on the Iowa Medicaid website in October 2022.

B. Geo-mapping

To assist Iowa Medicaid to identify HCBS residential and non-residential settings within the state of Iowa, the QIO HCBS Unit used a geo-mapping tool. Geo-mapping is a data collection tool that allows an address to be entered into a database from which a map may be generated showing locations by county, city, and street. Iowa used the first address collection tool data from 2016 to create a map of settings across the state to initially identify:

- All facilities in the state, by county including Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID), Nursing Facilities (NF), Institutions for Mental Disease (IMD), State Resource Centers (SRC), Residential Care Facilities (RCF) and Assisted Living Facilities (ALF)
- All provider owned and controlled residential settings
- Locations of all non-residential service settings (day habilitation, adult day care, prevocational settings, and sheltered workshops).
- Clusters of HCBS waiver and Habilitation funded settings

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

Although geo-mapping was used primarily for initial discovery as described above, the tool is still available for future use as needed.

C. Quality Oversight Reviews

The QIO HCBS Unit is responsible for quality oversight of providers of HCBS waiver and Habilitation services. A quality oversight process of discovery, remediation, and improvement is used to assure compliance with the SA and all rules of the HCBS waiver and Habilitation programs. Quality oversight reviews include regular onsite periodic or certification reviews, focused desk reviews, targeted reviews, and specific settings assessments.

Periodic Reviews: All providers receive a periodic review once in a five-year cycle. During the review process, responses on the latest SA are verified to evidence found in member and personnel records, Iowa Administrative Code (IAC), Iowa Code, and Code of Federal Regulations (CFR).

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

Targeted Reviews: Providers may be subject to a targeted review based on a complaint towards a specific provider or a serious incident or pattern of incidents. Complaints and incidents may be related to HCBS setting rule non-compliance. A targeted review may be completed as a desk review or an onsite review.

Focused Reviews: Providers are randomly selected each year to participate in a focused review, but all providers receive a focused review once in a five-year cycle. The focused review subject is determined annually and based on historical data and Iowa Medicaid need. The SFY17 and SFY18 focus topic was HCBS setting readiness and compliance in non-residential settings. See section VIII. B. for data from these reviews. *The proposed SFY23 topic is HCBS settings compliance in residential settings including verification of responses on selected member's most recent residential assessment.*

New section:

Setting Assessments: *The HCBS Waiver and Habilitation Settings Assessment tool (Attachment E) has recently been adapted from the previously used "non-residential review" tools and "residential site review" tool, based on experience from using the tools and feedback from CMS. The questions on the settings assessment tool will also be incorporated into the regular review checklists used for periodic and certification reviews and the tool may also be used as a stand-alone assessment tool for special circumstances. A provider's specific residential or non-residential location may be selected for a setting assessment based on a potential concern related to HCBS*

settings requirements. Settings that may require a setting-specific assessment include settings that fall into a "heightened scrutiny" category which are outlined in section VII. Heightened Scrutiny. The categories include settings that are also a publicly or privately operated facility that provides inpatient institutional treatment, settings that are 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 HCBS waiver or Habilitation services from the broader community of individuals not receiving Medicaid HCBS.

A potential concern which may result in a settings-specific assessment may be discovered through the initial geo-mapping project, through the annual provider self-assessment and address collection process, regular quality oversight reviews, residential assessment responses, incidents or complaints related to HCBS settings requirements, and any other member-specific compliance concern. The QIO HCBS Unit may also be alerted to a setting requiring a setting assessment from an outside party such as another state unit, an MCO, or community member. Responses to Iowa's Participant Experience Survey (IPES) tool may also be used to discover a potential setting requiring this specialized assessment. The setting assessment acts as Iowa's "first level" heightened scrutiny review tool and is one way to discover settings that may need a heightened scrutiny review from CMS.

Updated explanation:

***Application Review**: Prospective providers and existing providers adding additional services, are required to apply to Iowa Medicaid to be enrolled to deliver the desired services. The QIO HCBS Unit reviews applications for any services subject to quality oversight and review (Reference section B attachment A Provider SA). As part of the application review, the QIO HCBS Specialist works with the applicant to develop policies and procedures in line with all requirements of IAC, Iowa Code, and CFR including HCBS settings requirements. Applicants must demonstrate through written policies and procedures and attestation on their initial provider SA that they are compliant with requirements before the application can be approved. New providers participate in an onsite review within 270 days of beginning service provision. At this time, the QIO HCBS Unit will follow the regular certification or periodic review process to ensure the provider properly implemented the approved policies and procedures and to validate responses on their initial SA.*

Updated explanation:

A provider's approved SA is used by the QIO HCBS Unit to conduct provider reviews and other quality oversight activities. The SA checklist is incorporated into quality oversight review processes as described is section VII. A. Provider Self-Assessment. Reviews include review of the provider's responses on their latest SA and progress

towards any outstanding CAP from the previous SA, review of the provider's written policies, procedures, review of the provider's Quality Improvement (QI) plan assuring the provider has a systemic and planned approach to monitoring and improving performance. All review processes also include a look at a variety of evidence to verify SA responses were accurate, policies and procedures were carried out appropriately, and that the provider is compliant with all applicable requirements and best practices. Evidence may include member records, personnel and training records, service documentation, residential assessments for selected members, onsite tours, information from external sources such as licensing and accrediting entities, and incident and complaint information. Quality oversight reviews include review of systems the provider has in place for meeting settings requirements in all environments where they provide HCBS waiver or Habilitation services. A report of findings is generated by the QIO HCBS Specialist and sent to the provider including detailed narratives to support the findings.

When any issue of non-compliance, including those related to HCBS settings requirements, is identified through any of the review processes, the provider is required to develop a corrective action plan (CAP) to address the issue. The CAP is submitted to the QIO HCBS Specialist within thirty days of receipt of the report of findings. The QIO HCBS Specialist works with the provider until the CAP is determined to be fully acceptable, and it may take several attempts before the provider is able to develop a fully acceptable CAP. The provider is allowed ten days between CAP attempts. Once all CAP areas are approved, the provider has sixty days to carry out the CAP before a "compliance review" is completed. Compliance reviews may be conducted as a desk review or onsite review. At this phase in the review process, the QIO HCBS Specialist requests specific evidence to demonstrate that the CAP was successfully implemented, and compliance was achieved. Compliance findings are reported to the provider following the same process as CAP findings. Compliance may be achieved all at once or may be achieved in phases, in which case the compliance process continues until full compliance can be demonstrated in all areas. Providers are given thirty calendar days between compliance attempts. Providers unable to develop an acceptable CAP or providers unable to successfully implement a CAP and achieve compliance, may have sanctions imposed. Sanctions may include probation, suspension, or termination from the Medicaid program. Any adverse action taken by the QIO HCBS Unit may be appealed by a provider.

The COVID-19 Public Health Emergency (PHE) and subsequent PHE workforce challenges have had a large impact on the ability of the QIO HCBS Unit to carry out quality oversight and review activities. Onsite reviews were suspended from mid-March 2020 until July 2021. All reviews were completed as desk reviews which impacted the

ability to tour sites and to access full records. This caused a significant increase in administrative burden for the provider and the QIO HCBS Unit to complete a review. Although there has been a return to onsite reviews, providers faced with PHE related workforce challenges have been forced to utilize administrative and leadership staff in direct service roles to meet the needs of members. It has therefore been increasingly difficult for providers to respond to quality oversight and review requirements timely and adequately.

Due to the PHE, all adult day care and day habilitation sites were required to close for several weeks in 2020. Many community-based employers ceased operations at the same time. Additionally, opportunities for community integration were limited due to public closures related to the PHE, such as movie theatres, gyms, restaurants, etc. Although these experiences were common to all Iowans, HCBS waiver and Habilitation members and providers were uniquely affected. As members became more isolated to their homes and more dependent on their residential services, providers implemented emergency procedures to protect members and staff from illness and ensure member's staffing needs were met. Practices such as limiting access to the community and visitors, masking, isolating, and temporary consolidation of members to other residences would otherwise be considered incongruent with HCBS setting requirements but were necessary to manage through the PHE. As it relates to quality oversight and review of HCBS settings requirements, it became increasingly difficult to monitor and ensure member choice with restrictions related to the PHE. As the PHE unwinds and providers reestablish "typical" business practices, reassessments have been incorporated into our standard oversight processes.

D. Residential Setting Assessments

The Home and Community Based Services (HCBS) Residential Setting Member Assessment (form 470- 5466 - Attachment C) is used as a tool to assess, discover, and remediate HCBS settings issues in residential sites and with individual members. The tool is administered by a member's integrated health home (IHH), case manager or managed care community-based case manager (hereby referred to as "case manager") to assess a member's place of residence for compliance with the setting rules. Case managers were selected to administer the residential assessments with members because they are already required to meet with the member face-to-face in their place of residence at least quarterly and because a case manager is likely to have more familiarity with the member's situation ongoing.

The HCBS Residential Assessment form is composed of four sections: demographics, instructions, member outcomes, and final outcomes. The residential assessment form:

- Identifies if a member will complete a partial or full assessment. Members who live with their family, own their own home, or rent a living unit from a community landlord that is not owned, operated, or controlled 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 personal 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. Members exercise their rights and responsibilities.
9. Services are individualized to the needs of the member.

The nine-member personal outcomes are expected to be present in a member's life. Each outcome is listed separately and has a series of questions which must be responded to by the case manager as they talk with the member, family, or provider staff, to assist with determining how the member personally defines the outcome and whether the outcome is present in the life of the member. The presence of the nine personal 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 exhaustive and the case manager may ask additional questions based on the response from the member and their representatives present during the assessment. The interview must include the member and may include others with knowledge of the member's needs and preferences (parents, guardians, provider staff, etc.) if the member is unable to comprehend or respond to the questions because of a cognitive, verbal, or other

impairment. 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 case manager cannot make a final determination, additional guidance questions are needed. For each Yes or No response, the case manager must provide evidence that supports the final response.

Section IV. “The Bottom Line” of the residential assessment asks the case manager to answer three questions to summarize the outcome of the interview with the member. The three outcomes help 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 questions/outcomes are:

- 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 Iowa Medicaid by the member’s case manager through Iowa Medicaid’s Portal Access (IMPA). On a monthly basis the QIO HCBS 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 by the QIO HCBS Unit.

The follow-up process starts with a designated team member from the QIO HCBS Unit contacting the case manager to inquire about the “no” response. At that time, the case manager may identify that the member already has a specific limitation (i.e., rights restriction) documented in their person-centered plan. If that is the case, there is no further action required. However, if it is identified that that the negative outcome is identified as a provider or service provision issue, the designated QIO HCBS team member refers to the provider’s QIO HCBS Specialist for input. The QIO HCBS Specialist contacts the member’s provider to inquire about the identified issue. The provider is asked to provide an explanation or plan to remediate the issue immediately. For more extensive and pervasive issues, the QIO HCBS Unit may open a formal complaint.

Updated explanation:
When a complaint is filed with the QIO HCBS Unit, the QIO HCBS Incident and Complaint Specialist contacts all involved parties including but not limited to the member, the member's legal decision maker or caregiver, the member's case manager, and the provider in question. The contacts may result in a formal request of information to be sent to the case manager and provider requesting specific information such as person-centered plans and service documentation to better understand the circumstances and to review for all areas of potential non-compliance. The provider may be required to submit a formal CAP to remediate the issues identified in the residential assessment and through the complaint review.

Residential assessment "flags" are already used in the regular and ongoing review process as a piece of evidence to demonstrate the provider is truly meeting settings requirements in all environments where they provide HCBS waiver or Habilitation services.

The QIO HCBS Unit's regular quality oversight review process is currently being updated to match enhancements to the SA as described in section VII. A. Annual Provider Self-Assessment. As part of the regular review process, a sample of individual locations will be assessed for compliance with settings. Components of the Settings Assessment tool will be incorporated into the regular review checklist. Additionally, member experiences in terms of HCBS settings requirements will be evaluated by ensuring that the most recent residential assessment is reviewed for each member selected in the quality oversight review. Additionally, the proposed SFY23 Focused Review topic is HCBS settings compliance in residential settings including verification of responses on selected member's most recent residential assessment.

These enhancements to the regular review process and a SFY23 focus on verification of residential assessment responses will help Iowa ensure the validity of the residential assessments completed during the PHE and to ensure members' lives return to "normal" as the PHE unwinds. In-person visits with members were suspended for several months during the PHE. Residential assessments were administered virtually during that time which impacted the ability to effectively assess a member's residence. Being present in a location allows the case manager to witness interactions between the member and others in the setting and provides opportunities to apply other context clues to the overall findings of the residential assessment process.

E. 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 the QIO HCBS Unit for the fee-for-services (FFS) populations and each MCO for their enrolled members.

The QIO HCBS Unit calculates the minimum number of IPES that must be completed for each waiver and Habilitation to achieve a 95% confidence level based on HCBS waiver and Habilitation enrollment at a designated point in the year. The total number of needed participants for each waiver and Habilitation is divided by 12 so that members can be surveyed throughout the year. Each month, Iowa Medicaid randomly selects actual members from each program to receive the survey and provides the list of selected participants to the QIO HCBS Unit for completion. Any enrolled HCBS waiver and Habilitation member may be selected to participate in the IPES, including those receiving both residential and non-residential services.

To complete the survey, the interviewer or designee must first contact the member's case manager. The case manager is asked to verify contact information and provide any key information to make the IPES a success including information about the member's communication needs and wishes. The member also receives a letter alerting them about being chosen for participation in the survey. Each of these pre-interview contacts provide opportunities to let the interviewer know about any assistance or accommodations that may be needed to complete the IPES. The IPES interview is conducted primarily by phone but could be in-person if requested by the member. Although it is strongly encouraged that members contribute to the IPES interview, the member may choose to designate somebody to answer on their behalf.

Updated explanation:
When a member indicates a negative response to certain questions, the response is "flagged" for follow-up. Follow-up on a flagged question means the interviewer or designee contacts the member's case manager to explain the member's response and request that the case manager provide an explanation and/or remediation plan to the identified issue. The case manager typically must contact the member or their legal representative to talk about the member's response and determine a need for any additional education, plan updates, or other action to resolve the issue. An explanation or remediation plan must be provided within 30 days. The explanation or remediation plan is reviewed by a QIO HCBS Specialist to ensure the "flagged" concerns have been appropriately resolved. The QIO HCBS Specialist will work with the case manager until the "flagged" issue is remediated appropriately.

New section:

The IPES tool includes several questions that speak to the member's experiences related to HCBS settings requirements including the following:

1. *Do you feel you get to choose the things you do with your life?*
2. *Do you feel you understand your rights?*
3. *Were other agencies talked about before your providers were chosen?*
4. *Does someone help you if you don't understand your rights?*
5. *When a staff person is working with you, they should respect your rights. Staff can only limit your rights if you agree to it. Has staff stopped your from doing something you want to do?*
6. *Have you had to change a service provider/agency that you were working with?*
7. *Do you feel you have a part in planning your services?*
8. *Were you given a list or told the names of different services providers you could use?*
9. *There are different ways to calm a person down with restraint. Some of the ways include medicine, a shot, being held down, or being strapped down. Has this happened to you in the past two years?*
    a. *Have you told anyone on your team this happened?*
    b. *Has the plan been written telling others how to you if you become upset?*
10. *Did you decide to use this/these services providers?*
11. *Have you told anyone on your team you would more choice in picking the things you do?*

Beginning in SFY23, the QIO HCBS Unit plans to better align the regular quality oversight reviews with completed IPES. The list of members selected for each review will be compared to the list of members who have completed an IPES within a certain timeframe. Responses to questions outlined above will be part of the package of evidence that the QIO HCBS Specialist reviews to determine whether a provider is compliant with HCBS settings requirements.

IPES were suspended for Fee for Service members during the PHE. IPES were restarted in July 2021 when in-person visits were re-instated. For that reason, there is no IPES data for the end of SFY20 and all of SFY21.For that reason, there is minimal IPES data available for SFY20 and SFY21.

F. 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:

- 441 IAC Chapter 77 - Identifies HCBS waiver and Habilitation provider qualifications, standards, and requirements.
- 441 IAC Chapter 78 - Identifies HCBS waiver and Habilitation amount duration and scope of services. Identifies HCBS Habilitation program eligibility criteria.
- 441 IAC Chapter 79 - Identifies HCBS waiver and Habilitation financial rate structure, upper reimbursement rates, pricing, and cost reporting procedures
- 441- IAC Chapter 83 - Identifies HCBS waiver program eligibility criteria

The analysis of the IAC in the initial STP identified that, as a whole, the four IAC chapters listed above support HCBS members receiving services in integrated community-based 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 changes to the Habilitation program, and regulation changes at the state and federal level. As such, there are rules that required amending to support full implementation of the federal setting regulations.

Iowa has a long history of providing HCBS waiver and Habilitation supports and services to members that support the member's 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 and state plan HCBS Habilitation program) 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 does 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 for HCBS is 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 can 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, Iowa Medicaid 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.

VII. 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:

- **Category 1:** Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- **Category 2:** In a building on the grounds of, or immediately adjacent to, a public institution; or
- **Category 3:** 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 Category 1 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 Category 2 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, childcare 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 Category 1 settings 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 compare 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 Category 2 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 Category 3 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 those providers for heightened scrutiny review for approval. Final heightened scrutiny site approval by CMS must be secured by March 17, 2023.

New section:
Iowa Medicaid will submit settings to CMS for heightened scrutiny when settings meeting the criteria in category 1, 2, or 3 have been assessed and identified as overcoming the presumption that the settings are not HCBS. Findings of the initial onsite review findings from 2017 and 2018 identifies that no heightened scrutiny reviews were indicated.

A. Ongoing Heightened Scrutiny Review Process

After the initial statewide assessment of service providers completed in 2017 and 2018 to identify settings meeting the category 1, 2 & 3 settings criteria, Iowa will review new HCBS waiver and Habilitation service providers and settings that began service provision after the initial statewide assessment as well as ongoing review of existing settings to assure initial and ongoing compliance with the settings rule. The reviews will occur when:

- *New service providers apply to become enrolled HCBS waiver and Habilitation service providers (residential and non-residential)*
- *Existing enrolled HCBS waiver and Habilitation service providers apply to add new services (residential and non-residential)*
- *Existing institutional residential care settings convert to HCBS waiver and Habilitation service provision (e.g., ICF/ID facilities convert to HCBS waiver or Habilitation services)*
- *HCBS Waiver and Habilitation service settings previously found in compliance are reviewed through quality assurance activities and found to be out of compliance*

On an ongoing basis, the QIO HCBS Unit will review new provider applications to provide residential and non-residential services. The review process will assure a new provider is in compliance with the setting rules prior to enrollment as a HCBS Waiver or Habilitation service provider in the Medicaid program. A new provider may not bill for services until they are enrolled with Iowa Medicaid. New providers will be required to complete the HCBS Provider Self-Assessment and receive QIO HCBS Unit approval prior to service provision. The Provider Self-Assessment will identify service setting

where residential and non-residential services will be provided. Any new setting identified on the self-assessment as meeting criteria in categories 1, 2 or 3, will require QIO HCBS Unit approval prior to HCBS service provision and payment for services in the setting and may require a heightened scrutiny review and CMS approval.

The QIO HCBS Unit will review all new residential or non-residential settings developed by currently enrolled HCBS and Habilitation providers when the new setting meets the criteria in categories 1, 2 or 3. Settings must be reviewed and found in compliance with the settings rules prior to the provision of HCBS services in the setting. The QIO HCBS Unit will meet with the provider prior to the approval of the setting and conduct a site review.

The application process for new residential and non-residential services requires all new provider settings be screened by the QIO HCBS Unit against category 1, 2, and 3 criteria, using the HCBS Waiver and Habilitation Setting Assessment Tool (Attachment F). The assigned QIO HCBS Specialist will review the provider application and communicate with the provider to determine if a heightened scrutiny review will be needed prior service provision in the new residential or non-residential setting. The review will identify and verify how the provider assures:

- *Compliance with the required policy and procedures identified in the Provider Self-Assessment.*
- *Members within the setting have input in activities that will be available for participation within the setting.*
- *Individual member preferences are identified and reflected in daily activities within the setting.*
- *Members have individual choice in the activities in which they will participate.*
- *Person centered planning is incorporated into supports and services received within the setting.*
- *Activities are planned and provide opportunities for participation in the community.*
- *Member daily schedules are individualized and based on the member's assessed needs, wants, and preferences.*

Using the HCBS Waiver and Habilitation Setting Assessment Tool, the QIO HCBS Unit will assure providers meet the setting rules and determine if a heightened scrutiny review is needed prior to services provision. Possible provider outcomes include:

1. *The setting is in compliance with the settings requirements and does not require a heightened scrutiny review.*

2. *The setting could meet requirements for HCBS Settings with some remediation. The QIO HCBS Specialist must follow up with the provider to implement remediation plans before approving the site.*
    a) *Will be referred to CMS for heightened scrutiny review*
3. *The setting cannot meet requirements for HCBS Settings after remediation. QIO HCBS Unit begins the process to transition members to approved HCBS Waiver or Habilitation settings*

B. Heightened Scrutiny Public Comment Process

All provider heightened scrutiny reviews will generate a heightened scrutiny review report completed by the QIO HCBS Unit. The report will use the HCBS Waiver and Habilitation Settings Assessment Tool (Attachment E). The QIO HCBS heightened scrutiny review report will be made available on the STP website for public comment. When information is posted it can be found at the following link: https://dhs.iowa.gov/ime/about/initiatives/HCBS. Completed heightened scrutiny review reports will be posted to the webpage quarterly on January 1, April 1, July 1, and October 1, each year. Final reports that were written and completed within a calendar quarter will be posted on the first day of the following calendar quarter in which they were finalized. Heightened scrutiny reports will be posted for public comment for 30 days.

Public facing heightened scrutiny reports posted to the website will include the following:

- *Identify the provider name and address*
- *Non-residential setting address*
- *Residential setting address as permitted by HIPAA regulations.*
- *Identify the setting type (Adult Day Care (ADC), Prevocational, Day Habilitation (DH), residential, etc.) within each of the three categories*
- *Identify by category of the heightened scrutiny review (1, 2, and 3)*
- *Summary of findings of the QIO HBS Unit heightened scrutiny review including corrective actions required, as applicable*

When published for public comment, Iowa Medicaid will send notice to CMS STP transition team identifying the date and provider name that have been posted to the website.

After the public comment time period ends, Iowa Medicaid will evaluate the provider review report and summarize the public comments received during the public comment period. If all evidence collected supports the setting has the characteristics of an HCBS setting and not of an institution or having the effects of isolating, Iowa Medicaid will

submit an evidentiary package to CMS for heightened scrutiny review. Evidentiary packages will be submitted to CMS quarterly on or before the last day of the quarter in which the public comments were received. Iowa Medicaid will send all final heightened scrutiny reports in need of CMS review together in one communication

C. Timeline for Heightened Scrutiny submission to CMS

July 2022:

Iowa will post the first round of provider heightened scrutiny reports on the STP website on July 1, 2022, for all providers that have been reviewed for settings compliance and submitted an accepted CAP to the QIO HCBS Unit. The individual provider setting review reports will be posted to the website for through July 31, 2022, for public comment.

Providers that have outstanding CAP(s) will be notified by the QIO HCBS Unit that a CAP must be submitted and approved by the QIO HCBS Unit on or before July 31, 2022, in order to be considered for a heightened scrutiny review. Providers that submit and receive a CAP approval by July 31, 2022, will have a report posted for public comment on October 1, 2022.

August 2022:

The QIO HCBS Unit will review all public comments received and incorporate the findings into a heightened scrutiny report and submit to CMS for review.

Providers that do not have an accepted CAP by July 31, 2022, will be notified and the QIO HCBS Unit will begin the process to transition members to compliant settings

October 2022:

Second round of heightened scrutiny reports will be posted to the STP website

January 1, 2023:

Third round of heightened scrutiny reports will be posted to the STP website

The QIO HCBS Unit will verify that all member's transitioning to compliant settings have transitioned or have an active plan to transition to a compliant setting

The QIO HCBS Unit will verify that all providers that will not be in compliance by March 17, 2023, are prepared to end services on or before March 16, 2023

All outstanding CAPs must be accepted, and compliance review completed

All member transitions must be in place with progress being made towards identifying and transitioning members to a compliant setting.

March 2023:

All HCBS waiver and Habilitation settings must be in compliance with the HCBS rules settings. Setting not in compliance will not receive payments for HCBS services effective March 17, 2023.

D. Transitioning Non-Compliant Settings

There may be some settings that will not be able or willing to comply with the HCBS settings requirements by March 17, 2023. Iowa Medicaid has established a process for the timely transition of members from the non-compliant settings to another location that meets the settings standards or to alternative HCBS services that meet the members' needs.

The Member Transition Plan process is managed by the QIO HCBS Unit. When a provider has exhausted their opportunities and timeline to remediate issues and has received notification of the intent to transition members from that setting, the QIO HCBS Unit will notify the case managers of the affected members of the need and timeline to transition the members from the setting. The QIO HCBS Specialist will ensure receipt of the notification and will contact case managers and providers weekly until each member is successfully transitioned. The QIO HCBS Unit will also provide weekly updates to Iowa Medicaid on the status of the transitions. All member transitions must be completed no later than March 16, 2023.

VIII. Summary of Initial HCBS Settings Discovery and Remediation Results

Updated explanation:
As explained in section VI. Iowa's Systemic Assessment Process, Iowa Medicaid has taken a multifaceted approach to the identification, review, assessment, and evaluation of all residential and non-residential settings where HCBS waiver and Habilitation services are provided for the purpose of assuring all settings meet state and federal

rules and regulations. This section outlines the results after implementing the processes used for initial discovery of HCBS settings across Iowa and, if applicable, any updated data available from ongoing discovery, remediation, and improvement of HCBS settings. Plans for updates and enhancements to these processes are primarily described in section VI. Iowa's Systemic Assessment Process but may be further explained in this section.

Iowa's multifaceted approach includes:

- *Annual provider self-assessment, address collection, and attestation (form #470-4547)*
- *Geo-mapping technology*
- *Quality oversight and review, including review of residential and non-residential settings by the QIO HCBS Unit*
- *Residential assessments completed by each member's case manager*
- *Use of Iowa Participant Experience Survey (IPES) results for member experiences*
- *Administrative rules review and amendments*

Iowa's seven waivers and Habilitation programs collectively fund more than 30 different services. The chart below depicts each service by waiver or Habilitation program and indicates which services are presumed to meet the settings regulations or the setting where the service is provided is subject to Iowa's quality oversight and settings compliance review process. Settings marked with an X and highlighted green in the chart below, fully comply with the regulation because they are individualized services provided in the community or the member's private home and allow full access to the broader community according to individual needs and preferences. Services highlighted yellow have been reviewed by the QIO HCBS 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			X					
Adult Day Care								
Assistive Devices				X				
Assisted Living								
Behavioral Programming		X						
Case Management Services				X				X

Services by Program	AIDS/ HIV	Brain Injury	Children's Mental Health	Elderly	Health & Disability	Intellectual Disability	Physical Disability	1915(i) Habilitation
Chore								
Financial Management Services for Consumer Choices Option	X	X		X	X	X	X	
CDAC	X	X		X	X	X	X	
Counseling	X				X			
Day Habilitation								
Emergency Response		X		X	X	X	X	
Environmental Modifications			X					
Family and Community Support			X					
Family Counseling & Training		X						
Home-Based Habilitation								
Home Delivered Meals	X			X	X			
Home Health Aide	X			X	X	X		
Homemaker	X			X	X			
Home/Vehicle Modifications		X		X	X	X	X	
In-home Family Therapy			X					
Interim Medical Monitoring & Treatment								
Mental Health Outreach								
Nursing	X			X	X	X		
Nutritional Counseling				X	X			
Prevocational Services								
Respite	X	X	X	X	X	X		
Senior Companion				X				
Supported Community Living								
Specialized Medical Equipment		X					X	
Residential-Based Supported								

Services by Program	AIDS/ HIV	Brain Injury	Children's Mental Health	Elderly	Health & Disability	Intellectual Disability	Physical Disability	1915(i) Habilitation
Community Living (for children)								
Supported Employment		X				X		X
Therapeutic Resources			X					
Transportation		X		X		X	X	

Key:

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

A. Annual Provider Self-Assessment Results

Updated explanation:
The 2014 provider SA was the first SA to include requirements for HCBS settings and a first attempt at collecting specific locations of services. By 2016, the SA process and addition of the address collection tool, allowed for more effective data analysis including the geo-map project. The SA and address collection tools continue to be perfected. Information obtained from the annual provider SA and address collection are found throughout this STP.

B. Quality Oversight and Review Results

Updated explanation:
The QIO HCBS Unit conducted initial baseline reviews of residential and non-residential settings throughout SFY17 and SFY18. Residential and non-residential settings were assessed through a site-specific assessment process. Residential settings assessments and provider attestation on the SA served as the site-specific assessment of residential sites. The SFY18 Focused Review served as the site-specific assessment of non-residential settings.

A total of 115 non-residential providers and 235 individual, non-residential sites were assessed. A provider may operate multiple sites, so the total number of individual sites is greater than the total number of providers. By the end of calendar year 2018, over 33,000 residential assessments had been completed for more than 29,000 unique

members. A residential assessment is to be completed annually and any time a member moves to a new residence so the number of completed residential assessments is greater than the number of individuals receiving a residential assessment. During that time, 70 residential assessments were "flagged" for follow-up on a settings-related outcome as described in section VI. D. Residential Assessments.

Based on the state's assessment, the following chart identifies the number of settings and the outcome of the assessment process by type of service provided. All the settings identified in the chart were reviewed by the QIO HCBS Unit. By rule, Supported Employment (SE) services are required to occur in an integrated community-based settings. The total number of SE sites reported are providers which are enrolled to provide SE and have received an onsite review.

Non-Residential Services by Setting Type

Name of service	Total # of Settings Assessed	# Of Settings in Compliance	# Of Settings with a CAP and may be compliant with changes	# Of Settings Reviewed for Heightened Scrutiny	Assuring Compliance	Ongoing Monitoring
Prevocational	69	60	9	0	All locations requiring a CAP (i.e., remediation) continue to be monitored for compliance based on their individual provider corrective action plans	State will monitor through the HCBS Provider Quality Management self-assessment and onsite reviews.
Day Habilitation	155	155	0	0	All locations requiring remediation continue to be monitored for compliance based on their individual corrective action plans	State will monitor through the HCBS Provider Quality Management self-assessment and onsite reviews
Adult Day Care	26	26	0	0	All locations requiring remediation continue to be monitored for compliance	State will monitor through the HCBS Provider Quality Management

					based on their individual corrective action plans	self-assessment and onsite reviews
Supported Employment	72	72	0	0	The Department will monitor individual service plans to assure that recipients are not authorized services in non-compliant settings.	State will monitor through the HCBS Provider Quality Management self-assessment and onsite reviews.

Assisted Living Settings

Name of service	Total # of Settings Assessed	# Of Settings in Compliance	# Of Settings with a CAP and may be compliant with changes	# Of Settings Reviewed for Heightened Scrutiny	Assuring Compliance	Ongoing Monitoring
Assisted Living Facilities	80	79	1	0	All locations requiring remediation continue to be monitored for compliance based on their individual corrective action plans	State will monitor through the HCBS Provider Quality Management self-assessment and onsite reviews

For a full list of current HCBS waiver and Habilitation providers subject to quality oversight and review, see Attachment F. To see the latest provider SA for each individual HCBS waiver and Habilitation provider, visit this link on the Iowa Department of Human Services website: https://secureapp.dhs.state.ia.us/HCBSprovider

C. Non-Residential Settings Focused Review Results

As indicated in previous sections, the SFY17 and SFY18 Focused Review topic was HCBS setting readiness and compliance in non-residential settings. Onsite reviews were completed for all HCBS providers in the state of Iowa who were enrolled to provide non-residential services (Adult Day Care, Day Habilitation, Prevocational and Supported

Employment Services). Each review followed the regular review process whereby the QIO HCBS Specialist and designees validated the provider's response on their last SA and reviewed the providers' written policies, procedures, QI plan, and a variety of evidence to verify SA responses were accurate, policies and procedures were carried out appropriately, and that the provider was compliant with all applicable requirements and best practices specifically related to HCBS settings requirements. As with all reviews, the onsite Focused Reviews reviewed evidence such as member, personnel and training records, service documentation, residential assessments for selected members, information from external sources such as licensing and accrediting entities, and incident and complaint information.

For this specialized Focused Review, the Non-Residential Review tool (Attachment B) was used as a guide to complete the review. This checklist is a subset of the full review checklist that is incorporated into the Certification and Periodic Review processes. Since 2014, when the setting criteria was incorporated in the SA tool, all residential service providers have been reviewed for residential and non-residential settings compliance during an onsite certification review (completed at a minimum every three years). By June 30, 2020, all other service providers would have received an onsite review of residential and non-residential settings through the Periodic Review process which is completed at least every five years.

Providers were also given an option to submit any additional material in support of compliance with CMS Final Setting Rule requirements. Many providers submitted special policies and procedures related to settings, activity calendars demonstrating community-based programming, and QI plans updated to include internal review of indicators related to achievement of full compliance with HCBS settings requirements.

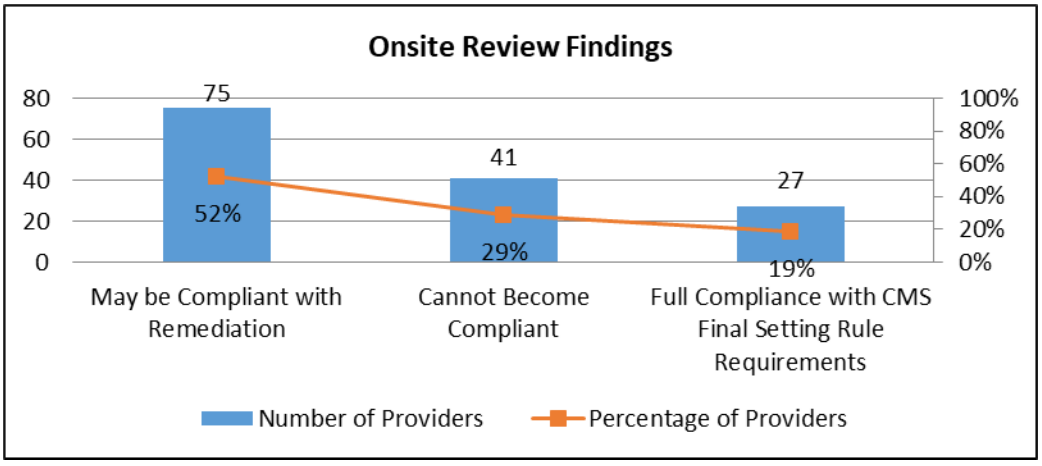
Provider policies and procedures were submitted to the QIO HCBS Specialist prior to the completion of the onsite setting review and were reviewed to ensure alignment with CMS Final Setting Rule and person-centered planning requirements. Member files were selected randomly and reviewed onsite. If a provider 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.

Each review included tours of every adult day care, day habilitation and site-based employment site operated by the provider to ensure the physical setting aligned with CMS Final Setting Rule requirements. For providers who offered non-residential

services in 100% integrated community settings, these onsite Focused Reviews were conducted at the agency's main administrative building. Although the SFY17 and SFY18 Focused Reviews offered a point in time look at all non-residential settings in the state of Iowa, regular, ongoing quality oversight and reviews processes include review of the same settings information to ensure ongoing compliance.

Providers will have until March 17, 2023, to be in full compliance with the settings rules.

In SFY17 and SFY18, 115 Focused Reviews for non-residential providers were completed. Approximately 60% of the state's HCBS waiver and Habilitation providers are enrolled to provide multiple non-residential services. Thus, multiple onsite tours were conducted for many providers. It was determined that 19% (n = 27) of providers were compliant with CMS Final Setting Rule requirements without remediation, 52% (n = 75) may be compliant with remediation, and 24% (n = 35) cannot become compliant. At this time, no providers had been put forth for heightened scrutiny.



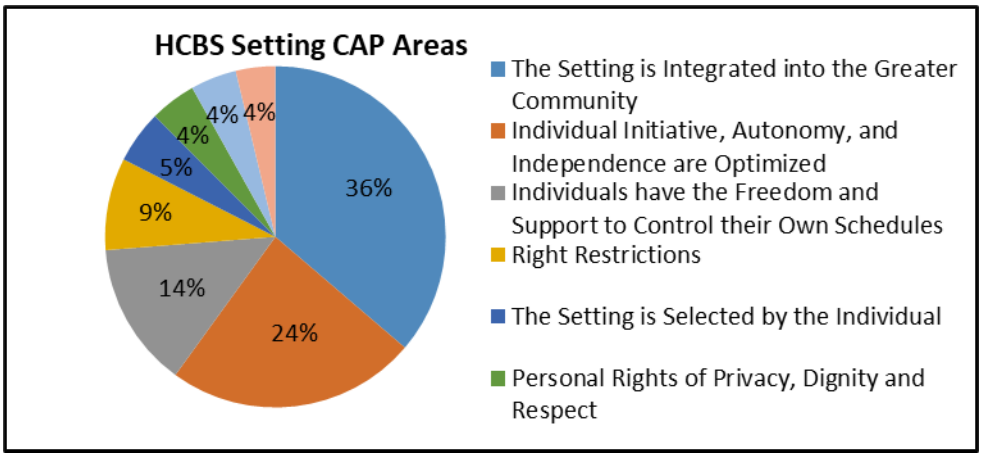
Providers who were determined to be in compliance with CMS Final Setting Rule Requirements (n=27) were not required to submit any additional follow-up material.

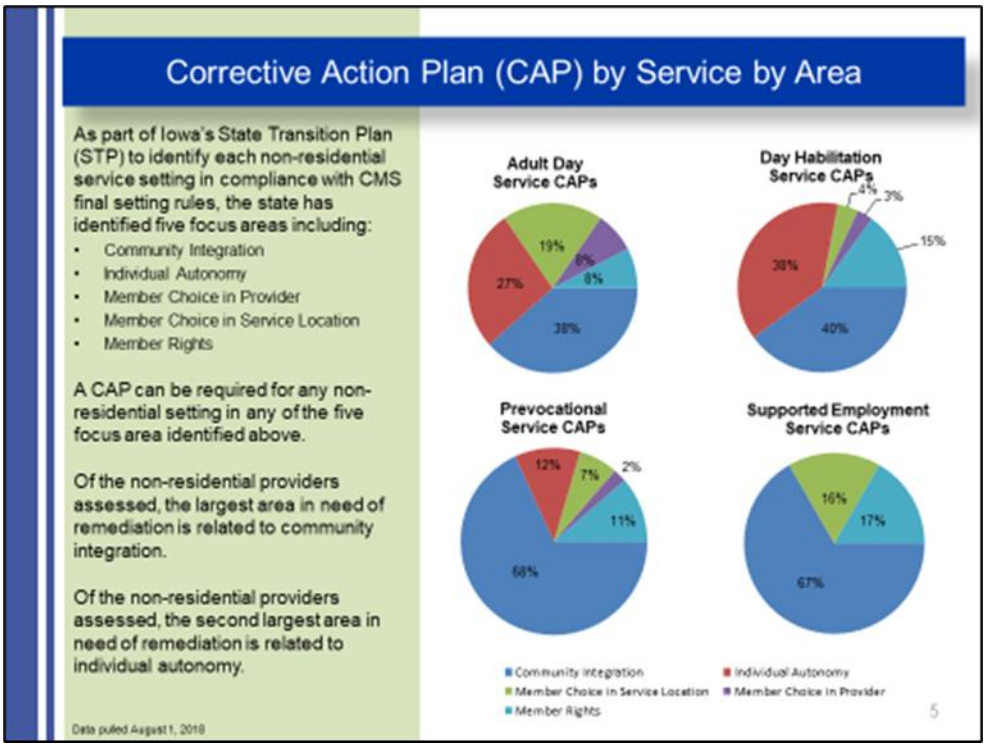
Providers who may be compliant with remediation (n=75) were required to submit a CAP for any area that was not compliant with CMS Final Setting Rule requirements. CAPs could be required in up to 20 different areas. See Attachment B for a copy of the review tool which was incorporated into all review 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

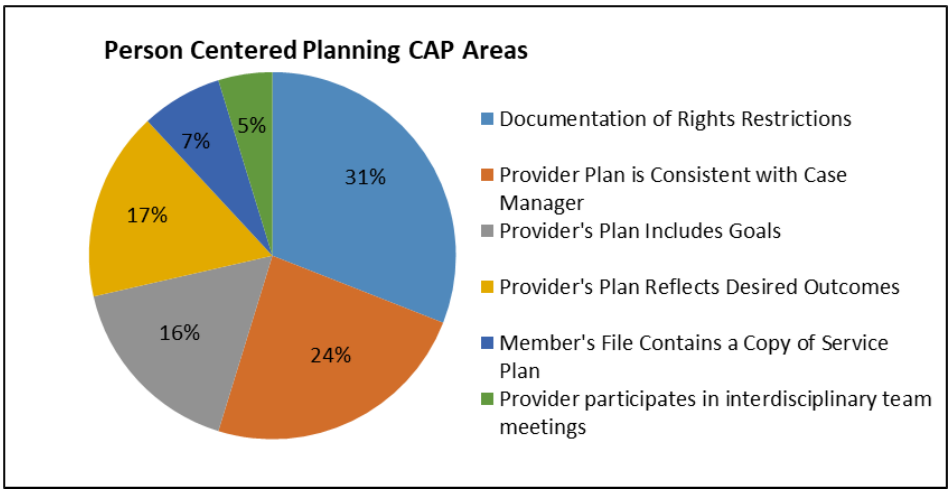
completion of the 2014 Annual Provider Quality Management Self-Assessment or in subsequent years.

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 and these reviews were specific to non-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 QIO HCBS Unit with any current plans to come into compliance with CMS Final Setting Rule requirements.

Providers who are required to submit a CAP have 30 days from the date of the QIO HCBS 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, 2023. A CAP can be accepted, partially accepted, or denied. Technical assistance was provided by the QIO HCBS 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 SFY19, the QIO HCBS Unit completed a Focused desk review, onsite Certification, or onsite Periodic Review for all providers who were 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 SFY17 and SFY18 review year identified completion dates prior to the SFY19 review. The QIO HCBS Unit reviewed previously submitted Annual Provider Quality Management Self-Assessments 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 QIO HCBS 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.

Since 2015, 33 providers dis-enrolled from non-residential services or transitioned member from prevocational services to supported community living services. As of March 1, 2020, there are 110 non-residential providers providing services in the State of Iowa. Of those 110, 99 providers are compliant while 11 prevocational providers are in the process of implementing a corrective action plan to become compliant. Settings that remain out of compliance include prevocational services, there are four providers that may not be able to meet compliance as they provide prevocational services in a sheltered workshop setting.

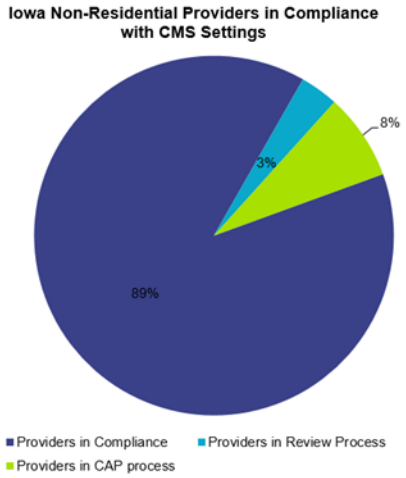
HCBS Providers in Compliance with CMS Settings

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

Data pulled May 23, 2019

3

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

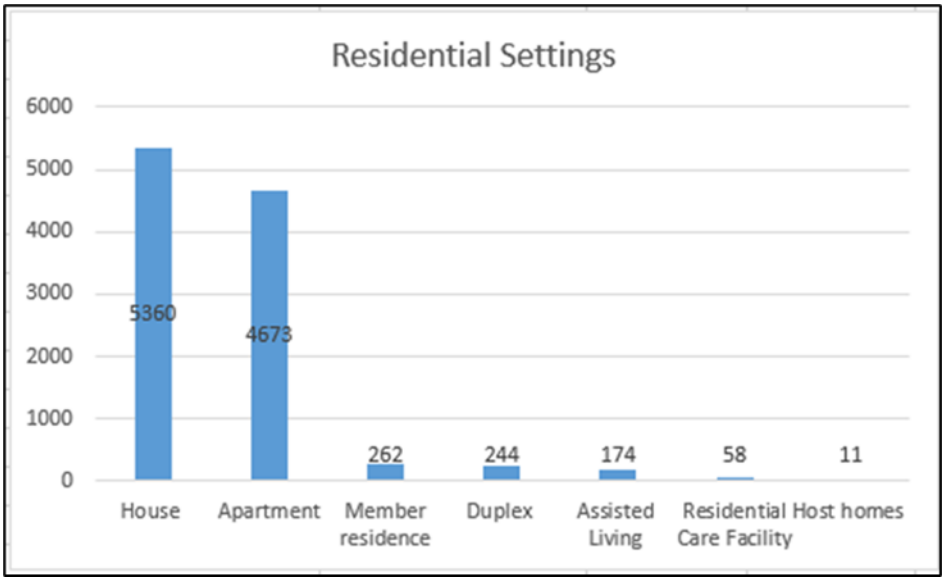
Provider Name
Skyline Center, Inc.
Southern Iowa Resources for Families, Inc.
Stepping Stone Family Services
Successful Living
Systems Unlimited Inc.
TASC Inc. / TASC
The Arc of East Central Iowa
The Larrabee Center
The Spectrum Network
To the Rescue
Unlimited Services, Inc.
Van Buren Job Opportunities
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

Data pulled May 1, 2018
*Indicates providers who were in full compliance with CMS Final Setting Rule Requirements prior to on-site

D. Residential Assessment Results

As described in section VI. D., Iowa developed and implemented the HCBS Residential Setting Member Assessment (form 470-5466) to assess individual member residences for compliance with HCBS settings requirements. Certain questions on the residential assessment are “flagged” for follow-up when a negative response is indicated.

The chart below demonstrates the types of residential settings that were reported by providers through the 2018 provider SA address collection tool. There were 10,779 total residential settings reported.



To date, the HCBS Residential Member Assessment has been completed with 27,192 unduplicated members. During SFY19, the QIO HCBS 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 QIO HCBS Unit received a new residential assessment for the member that no longer requires follow-up.
- “Entry Error” means the QIO HCBS Unit contacted the CM or CBCM and they advised they entered “No” in error.
- “In-Process” means the QIO HCBS 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 QIO HCBS Unit verifies that the individual limitations are 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.

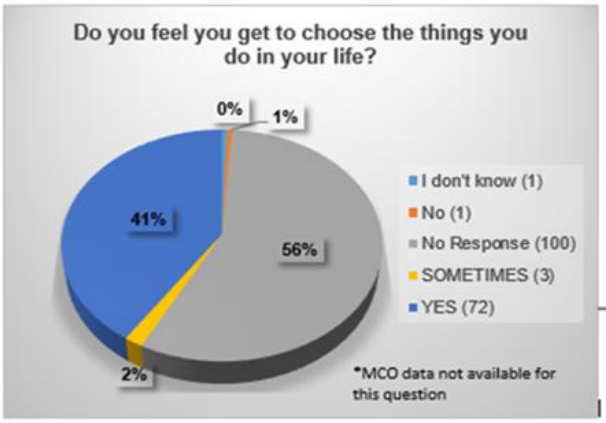
The QIO HCBS Unit will continue to aggregate and monitor the residential assessments monthly and follow up with all identified issues. A Residential Assessment report is developed by the QIO HCBS Unit and reviewed by the HCBS Quality Oversight committee on a quarterly basis.

E. IPES Survey Results

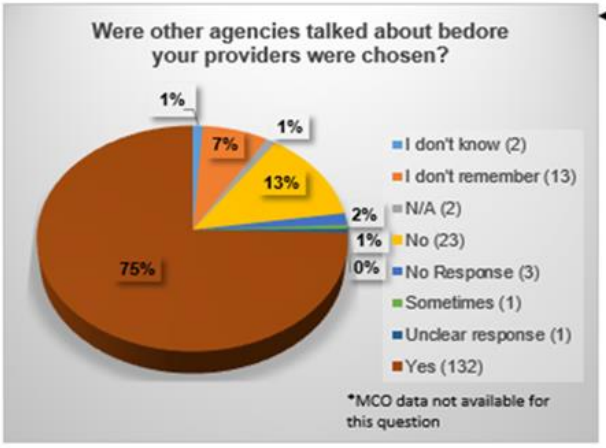
Updated explanation:
IPES has been used by Iowa to understand member’s experiences with HCBS for several years. Several questions on the IPES speak directly to HCBS settings requirements. See VI. E. for the list of questions. In final version of the STP from 2019, graphs were provided to analyze data specific to each question as a means of establishing a baseline for member’s experiences related to HCBS settings requirements. CMS notes some discrepancies between the number of IPES reported to have been completed versus the number of responses demonstrated in the graphs. The data discrepancy is noted and will be more closely monitored in the future. However, it was generally determined that the majority of members receiving HCBS felt 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.

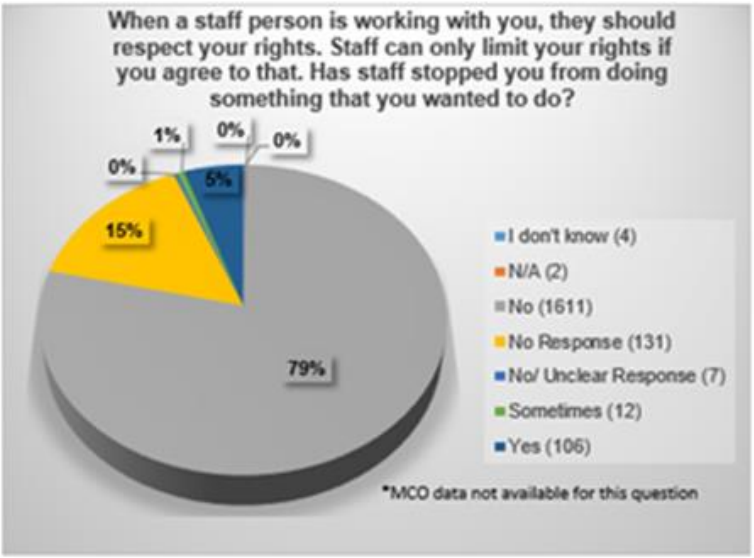
The state will continue to use IPES results on an individual member basis, combined with results from other assessment activities as described in the final STP, to ensure compliance with the regulations. The information will be gathered by the QIO HCBS Unit monthly and incorporated into the QIO HCBS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

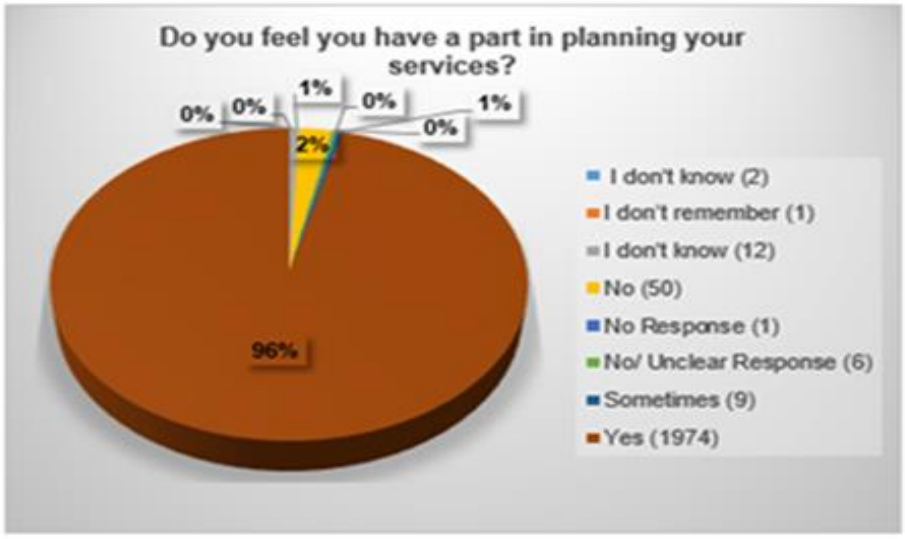
The following are the IPES results from SFY19 which were included in Iowa's last STP. The graphs reflect responses to questions centering on individual initiative, autonomy, and independence in making life choices.



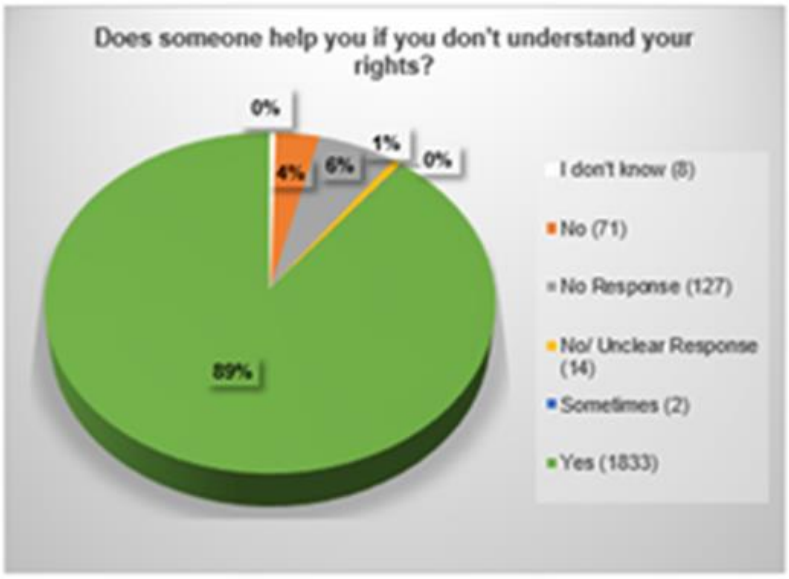
Members responding "No" or "Sometimes" were asked this follow up question:

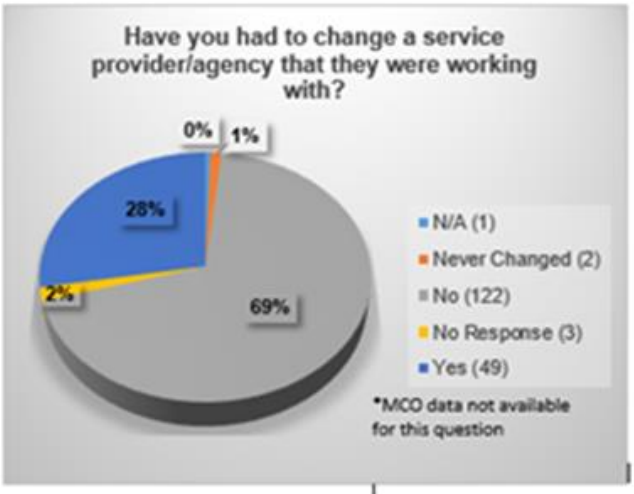




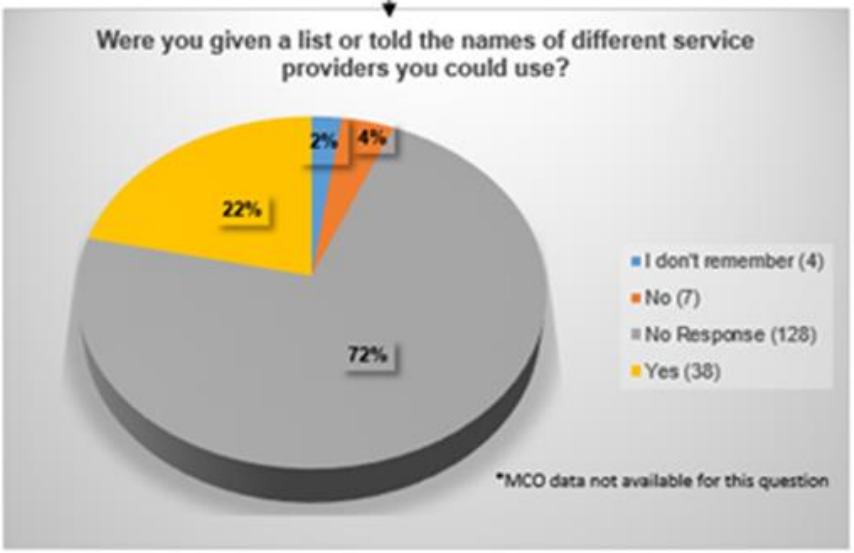


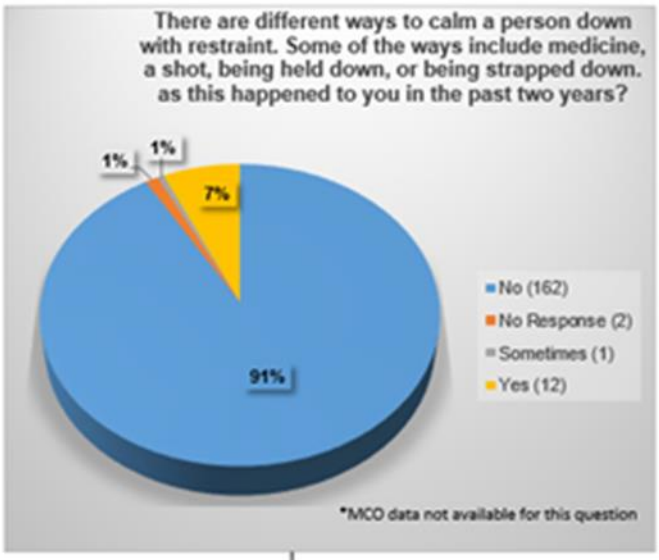
Members responding anything other than "Yes" were asked this follow up question:



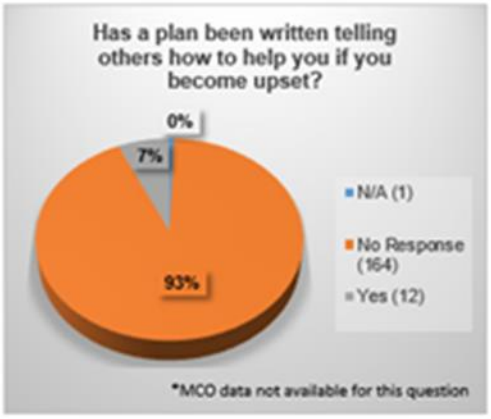


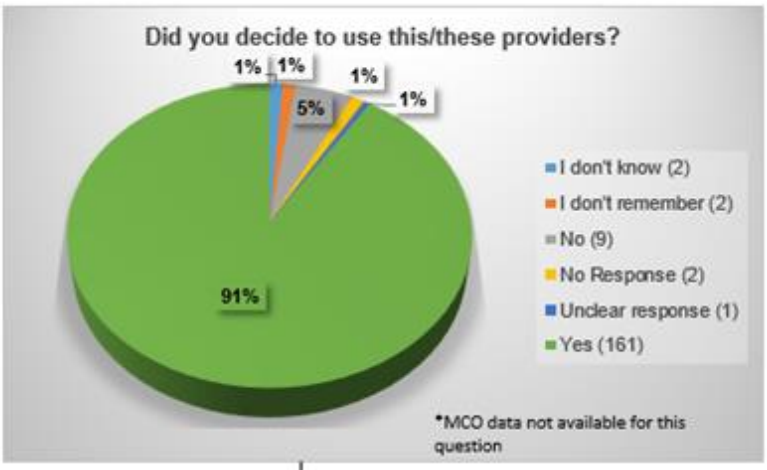
Members responding "Yes" or "I don't remember" were asked this follow up question:



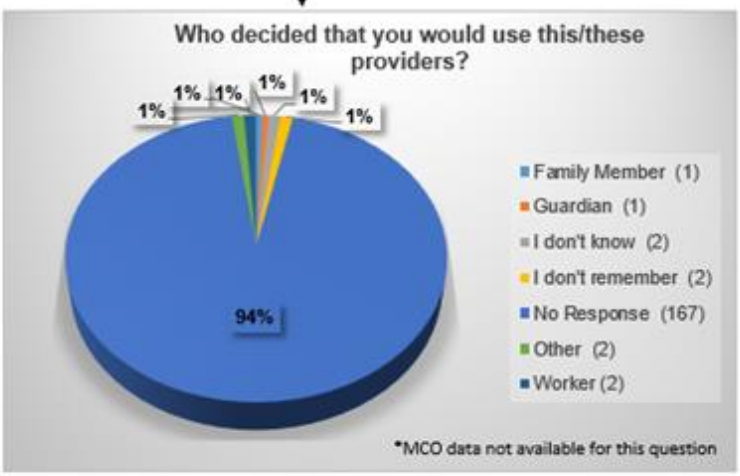


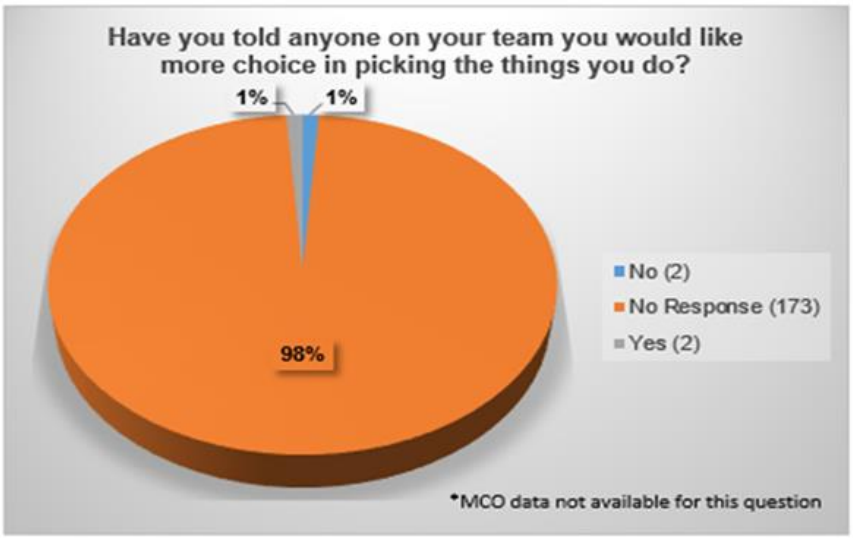
Members responding "Yes" were asked these follow-up questions:





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





F. Heightened Scrutiny Reviews

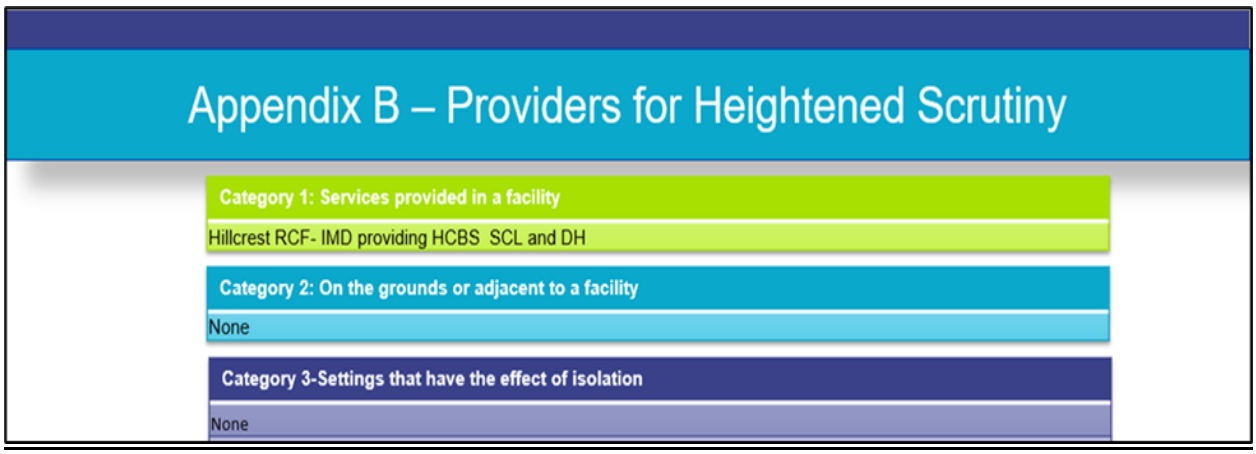
Thirteen providers were initially identified through the geo-mapping process as potentially requiring heightened scrutiny. The QIO HCBS Unit categorized each setting as follows.

- Category 1 - HCBS services being provided in a publicly or privately operated facility that provides inpatient treatment
- Category 2 - HCBS services are being provided on the grounds of, or adjacent to, a public institution
- Category 3 - HCBS services are provided in a setting that has the effect of isolating individuals receiving HCBS Services form the broader community of individuals not receiving HCBS

No category 1 providers were identified by the QIO HCBS Unit.

One category 2 provider was identified and terminated services in the location as they were unable to develop a CAP to come into compliance way to make the setting compliant.

Twelve category 3 agencies were identified by the QIO HCBS Unit. All providers submitted CAPs and the QIO HCBS Unit identifies that all locations were in full compliance prior to the due date for Heightened Scrutiny packet prior to July 1, 2020. Per CMS guidance, providers that were in full compliance with the HCBS Settings rule by July 1, 2020, are not required to go through the heightened scrutiny process. Based on the initial review and follow up CAPs, the QIO HCBS Unit and Iowa Medicaid did not submit any setting for a heightened scrutiny review. All providers received a follow-up review and provided evidence that the CAP was implemented and submitted evidence of compliance



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 support; additional rule language needed to clarify CMS setting regulations
441—IAC—77.34: AIDS/HIV Waiver Conditions of Participation for Providers	The majority of rules support; 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 support; 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

The State of Iowa – DHS has not required any members be transitioned from a setting at this time, some settings have voluntarily transitioned members. Individuals affected by this worked with their case manager to ensure a person-centered approach was competed for the transition. Should the providers that were identified they may come into compliance with changes, decide not to make modifications members would need to be transitioned to another provider. One residential setting would impact one member and the non-residential settings would impact 151 members.

G. Administrative Rules Review and 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 Habilitation program member eligibility and HCBS Waiver and Habilitation provider service delivery
- Chapter 79 - applies to HCBS provider reimbursement
- Chapter 83 - applies to HCBS Waiver member eligibility

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

Based on the analysis of the rules, Iowa Medicaid 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 members 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 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 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 regarding 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 QIO HCBS Unit. The QIO HCBS Unit uses the Provider Self-Assessment as the foundation of HCBS settings compliance. The Self-Assessment is used by a provider and the assigned QIO HCBS Specialist to look at the provider specific setting(s) and review for compliance with the rules. The QIO 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 Iowa Medicaid 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 (the IPES asks members questions about individual initiative, autonomy, and independence in making life choices).

Ongoing Monitoring of Residential and Non-Residential Settings

Iowa's approach for the monitoring of residential and non-residential settings compliance prior to and after the March 17, 2023deadline 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 continue to be submitted to the QIO HCBS 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 QIO HCBS Unit will gather member residential assessment information monthly and report to Iowa Medicaid 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 QIO HCBS 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 QIO HCBS Unit will gather member IPES information monthly and report to Iowa Medicaid Quality Oversight committee quarterly on the findings of the assessment.

The QIO HCBS 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 QIO HCBS 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, 2023, will be terminated for all services rendered in the setting until compliance with the settings rules is demonstrated and confirmed by the QIO HCBS Unit.

In an ongoing effort to better communicate quality assurance oversight activities concerning provider compliance with the HCBS settings rules, Iowa Medicaid will make all HCBS provider annual Self-Assessments available to the public for review. By July 1, 2020, Iowa Medicaid will post all final provider self-assessments on a dedicated webpage and annually update the Provider Self-Assessments each July 1st. In addition, beginning January 1, 2021, Iowa Medicaid will post all provider

periodic and certification reports to a dedicated DHS webpage. The reports will include all onsite findings, corrective actions identified, and all follow up compliance review findings.

Iowa Medicaid is the state entity responsible for the monitoring and oversight of all HCBS Waiver and Habilitation Program services. Iowa Medicaid 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, Iowa Medicaid 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, Iowa Medicaid 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, and providers to develop corrective action plans to come back into compliance.

IX. Attachments

A. Attachment A: Home- and Community-Based Services (HCBS) 2021 Provider Quality Management Self-Assessment

https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

B. 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				
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				
5) Individual choice regarding services and supports, and who				
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				
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				
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				

13) Provider owned or provider controlled home has entrance doors lockable by the individual, with only appropriate staff having				
14) In a provider owned or provider controlled home, individuals have the freedom to furnish and decorate their sleeping or living				
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				
4) Provider's service plan includes interventions and supports needed to meet the individual goals with incremental action steps,				
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				

Review Findings				
III. Providers are required to develop and implement a Quality Improvement (QI) plan. This plan must have a systematic, organization wide, planned approach to	**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				
2) Discovery: 2.a) Collecting and reviewing data to identify issues to be monitored for quality improvement				
2.b) Ongoing review of responses to all member/stakeholder input to determine the need for				
2.c) Ongoing review of member records to include medication management, health and safety, incident				
3) Remediation: The development of a plan to address areas of improvement identified during discovery, to include specific timelines for				
4) Improvement: Summary of QI activities to include monitoring the impact of remediation plan				
Review Findings:				

C. Attachment C: Residential Assessment Tool

The Home- and Community-Based Services (HCBS) Residential Setting Member Assessment can be located at the following link: 470-5466 HCBS Residential Setting Member Assessment (state.ia.us)

D. Attachment D: Promulgated Rules

This attachment contains strikethrough text. If you use a screen reader to view this content, please adjust your reader's settings to accurately read strikethrough text.

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 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 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 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 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 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 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. Member-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 member 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 member 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 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 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 paragr~~aphs 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.

E. Attachment E: HCBS Waiver and Habilitation Setting Assessment Tool

HCBS Waiver and Habilitation Setting Assessment Tool

Provider Name

Setting Name

Setting Information

Provider Name:	Setting Name:
Street address of setting:	Date of site assessment:
Contact person:	Phone:

Funding and Services in this Setting

Mark all funding sources and services provided in this setting.

HCBS Waiver/Habilitation	Service(s)
☐ AIDS/HIV Waiver	☐ Adult Day Care
☐ Brain Injury Waiver	☐ Assisted Living Service
☐ Children's Mental Health Waiver	☐ CDAC Agency
☐ Elderly Waiver	☐ Day Habilitation
☐ Health and Disability Waiver	☐ Home Based Habilitation
☐ Intellectual Disability Waiver	☐ Interim Medical Monitoring Treatment (IMMT)
☐ Physical Disability Waiver	☐ Prevocational services
☐ Habilitation	☐ Supported Community Living (SCL)
☐ Money Follows-the-Person (MFP)	☐ Residential-Based SCL for children (RBSCL)
	☐ Supported Employment

	☐ Intensive Residential Service (IRS) ☐ Other:

List the number of HCBS funded members and non-HCBS funded members served in this setting.	HCBS funded: Non-HCBS funded:
Is this setting provider owned or controlled*?	☐ Yes ☐ No
Is this setting an existing location or a new or perspective location?	☐ Existing ☐ New ☐ Perspective
How was it determined that the organization needs a site-specific review?	☐ Residential Assessment ☐ Address Collection Tool ☐ Quality Oversight review ☐ Incident or complaint ☐ Referral or notification ☐ New site/location ☐ Other:
What is the reason for the Settings Assessment?	☐ Setting is within close proximity of other HCB service sites ☐ Setting is associated with facility care ☐ Setting is disability and/or aging specific ☐ Member specific compliance concern ☐ Setting limits access to the community ☐ New or perspective site ☐ Other:

Home and Community-Based Services (HCBS), whether residential or nonresidential, must be provided in integrated, community-based settings that support members' 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, to the same

degree of access as individuals not receiving HCBS. HCBS services are required to be provided in such a way as to optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact. If an individual requires a restriction or limitation in one or more of the areas listed below, due process of that restriction or limitation should be outlined in their person-centered plan. Policies and procedures related to restrictive interventions should be followed. Answer the following questions about the location(s) identified to determine the level of compliance with the HCBS Settings rules and to identify areas in need of corrective action.

General Summary

Please provide a general summary of the setting and the reason for the setting assessment. Please be sure to include the following information in the description.
An explanation of any transition plans for the site (i.e., converting from an institutional setting to an HCBS setting).
An explanation of any concerns regarding the ability to meet HCBS settings rules in this site.
A description of what is being done to ensure members have a non-institutional experience if the members and/or the site is transitioning from an institutional setting to an HCBS setting.
An explanation of staff training that will be implemented to prepare staff for providing HCBS services if the staff are transitioning from an institutional setting to an HCBS setting. It is recommended that at a minimum staff receiving training on HCBS Settings rules, the difference between institutional versus HCBS services, member rights in HCBS, restrictive interventions in HCBS, member choice in HCBS, and other training required for HCBS providers. Provide a general summary of the setting and the reason for the setting assessment.
Provide a general description of the setting.

Setting Assessment

Provide a description of the physical location and structure of the setting. For example, the description might include but is not limited to a description of the neighborhood and neighbors around the site, an explanation of the site as a single-

family home or a multi-plex, a description of the proximately to community resources such as public transportation and shopping, and description of the layout of the site including the number of bedrooms.
Enter description here.

Answer the following questions to assess compliance with HCBS settings rules at this location. Corrective action may be necessary to remediate any areas that are not found to meet the HCBS Settings standards.

Provider policies and procedures	
Are the organization's policies and procedures aligned with HCBS settings requirements?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Physical location and characteristics	
Is the setting in close proximity to other locations where HCB services are provided? THINGS TO CONSIDER: • In a residential setting, is the residence a unit in a multi-plex (apartment building, quadraplex, duplex, boarding home) where most of the other units are occupied by people receiving HCBS services? • In a residential setting, is the residence located in a neighborhood, on a street, or on a block where other homes are occupied by people receiving HCBS services? • Is the setting co-located with other HCBS services or institutional care?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Are members made to share staff, programming, meals, transportation, or social/recreational activities between nearby settings (meals, transportation, social/recreational activities)?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is the setting disability and/or aging specific meaning that only people with a disability or specific disability or people over a certain age may attend or live in the setting?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is the setting located in an area which facilitates the member's ability to access community resources without being totally dependent on the service provider to access them?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Does the setting have available public transportation options or, where public transportation is limited, are other means of transportation available?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Does the setting offer a secure place for the individual to store personal belongings?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
For DH or ADC settings, does the setting afford a variety of meaningful non-work activities that are responsive to the goals, interests and needs of individuals?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Does the setting allow for individuals to have a meal/ snacks at the time and place of their choosing? THINGS TO CONSIDER: • Does the setting afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or mealtimes? • Does the setting afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs)? • Does the setting provide for an alternative meal and/or private dining if requested by the individual? • Do individuals' have access to food at any time consistent with individuals in similar and/or the same setting who are not receiving HCBS services and supports? • Are members made to eat with housemates, neighbors, or as a group?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
For a provider-owned or controlled residential sites, is the setting 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?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Are entrance doors to the member's house and/or bedroom able to be closed and locked by the member with only appropriate staff having keys?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Does the setting allow for unrestricted access to the full setting? THINGS TO CONSIDER: • Do members have full access to typical facilities in a home such as a kitchen with cooking facilities, laundry, and comfortable seating in the shared areas? • Do members have access to the same amenities such as a pool or gym used by others on-site? • Are there gates, Velcro strips, locked doors, or other barriers preventing members' entrance to or exit from certain areas of the setting?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is the setting physically accessible with no obstructions such as steps, lips in a doorway, or narrow hallways limiting the member's mobility in the setting or if they are present, have environmental adaptations been made to ameliorate the obstruction?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Is there a meaningful distinction between HCBS services and institutional care that is or was provided in the same location?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is there a meaningful distinction between HCBS services and institutional care that is or was provided in the same location?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is there shared programming between (meals, transportation, social/recreational activities) occurs between different homes/buildings	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Member experiences in the setting	
Are limitations, modifications or restrictions made to settings requirements supported by the individual member's assessed needs and justified in the person-centered plan?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Does the member or a person chosen by the member have an active role in the development and update of their person-centered plan?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is the setting where the member lives and receives services selected by the member from available options?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have access to the community to the same degree as their peers in the general community? THINGS TO CONSIDER: • Do members access (as desired and applicable) essential and non-essential shopping, recreation, restaurants, religious services, exercise, healthcare, personal grooming services, and visits with family and friends?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members come and go from the HCBS setting as desired?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have transportation options that allow them to access the community as desired?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Are members employed or active in the community outside of the HCBS setting?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have opportunities to pursue competitive, community employment as desired?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members participate in meaningful non-work activities in integrated community settings as desired?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Are members' rights to dignity and privacy respected?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Are members free from coercion?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do staff address members and communicate with members in a dignified manner?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is informal communication conducted in a language that the member understands?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Is personal assistance provided in private?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have privacy in their living space including their bedrooms and bathrooms?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members dress in their own clothes appropriate to the time of day, weather, and individual preferences?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members choose their roommates or housemates if sharing spaces?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have the freedom and support to control their own schedules and activities?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have access to such things as a television, radio, and leisure activities that interest them and can they schedule such activities as desired?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Are members able to have visitors of their choosing at any time as appropriate to the setting?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members know their rights regarding housing and when they may have to relocate?	☐ Yes ☐ No ☐ NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members control their personal resources?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
Do members have access to food at any time and choose when, what, where, and with whom to eat?	☐ Yes ☐ No ☐ NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Name of person completing this	**Title of person completing this form:**
Date Signed *(mm/dd/yyyy)*	

HCBS SPECIALIST USE ONLY
Compliance Determination ☐ Site meets requirements for HCBS Settings. Date: ☐ Site could meet requirements for HCBS Settings with some remediation. The HCBS Specialist must follow up with the provider to implement remediation plans before approving the site. Date remediation complete: ☐ No further action necessary. ☐ Post for public feedback.

☐ Refer to CMS further heightened scrutiny review.

☐ Category 1: Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment

☐ Category 2: In a building on the grounds of, or immediately adjacent to, a public institution

☐ Category 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

☐ Site could not meet requirements for HCBS Settings after remediation. Should be referred to CMS for further heightened scrutiny review.

HCBS Specialist Comments

F. Attachment F: Iowa's HCBS Waiver and Habilitation Providers

To see the latest provider SA for each individual HCBS waiver and Habilitation provider, visit this link on the Iowa Department of Human Services website: https://secureapp.dhs.state.ia.us/HCBSprovider

Iowa's HCBS Waiver and Habilitation Providers Subject to Quality Oversight and Review

Provider Name
43 North Iowa Transition and Employment Services
Abbe Center for Community Mental Health (Cedar Rapids)
ABCM Assisted Living Group: ELM SPRINGS APARTMENTS DBA MAPLE MANOR VILLAGE APT SPRING CREEK INDEPENDENT & ASSISTED WILLOW DALE ASSISTED LIVING BELLE HAVEN ASSISTED LIVING MULBERRY PLACE DBA COURTYARD ASSISTED LIVING DUTCHMANS OAKS INDEPENDENT AFTON OAKS INDEPENDENT EMERALD OAKS INDEP & ASSIST CARDINAL GROVE INDEPENDENT EAGLE RIDGE INDEPENDENT & ASSISTED LEAHY GROVE ASSISTED LIVING MILLS HARBOUR IND. ASSISTED CHERRY RIDGE IND. ASSISTED INDIAN CREEK IND. & ASSISTED SUMMIT HEIGHTS INDEP/ASSISTED PARK PLACE INDEPENDENT & ASSISTED DEER VIEW MANOR IND. & ASSISTED MAIN STREET MANOR ASSISTED LIVING ONEOTA VILLAGE ASSISTED LIVING SOUTHCREST MANOR II ASSISTED SOUTHFIELD WELLNESS ASSISTED
AbiliT Holdings (formerly Glenwood Place Assisted Living), LLC
Ability United LLC
Above & Beyond Home Health Care, Inc
Access Incorporated
Accura Healthcare of Pomeroy, LLC
Advanced Home Health Care Inc (Burlington)
Advancement Services of Jones County, Inc.
Advantages in Life, Inc.
Aging Services, Inc. including Milestones ADHC, Milestones in Marion, Pentacrest/Pathways ADHC
AL ADL, LLC dba Right at Home
AL Home Health Care
Always Best Care of the Cedar Valley
American Baptist Homes of the Midwest dba Crest Services

Provider Name
Ameriserve International II Inc.
AmeriServe International Inc.
Anamosa Aid PPCO LLC DBA Pinicon Place
Anchor Homes Inc.
Apple Valley Assisted Living, LLC (Clear Lake) Apple Valley Charles City, LLC Apple Valley, LLC Osage Apple Valley Assisted Living-Hampton
Area Residential Care Inc.
ARHC PHOTTIA01 TRS dba Addington Place of Fort Madison
ARHC PHOTTIA01 TRS LLC, dba Addington Place of Ottumwa
ARHC PHOTTIA01 TRS LLC, dba Addington Place of Ottumwa
ARHC SBBURIA01 TRS, LLC DBA Addington Place of Burlington
ARHC SFFDIA01 TRS LLC dba Addington Place Fairfield
ARHC SMMTEIA01 TRS, LLC DBA Addington Place of Muscatine
ARHC SPPLSIA01 TRS, LLC DBA Addington Place of Mt. Pleasant
Arlington Place of Grundy Center II
Arlington Place of Oelwein
Arlington Place Pocahontas
Asian Home Care (Tai Studies Center)
Atlantis Penn Place OPCO, LLC (Penn Place)
B&D Services
Balance Autism dba Homestead
Ballard Creek Community- Madrid Home
Bartles Lutheran Retirement Community (Aspen Cottage Assisted Living on DIA Site)
Behavioral Technologies, Corp
Bishop Drumm Retirement Center/Martina Place Assisted Living
Bledsoe Premier Home Health Care, LLC
Broadlawns Medical Center/ Broadlawns Residential Facility Oakland Home
Brown Deer Place
Builders of Hope Inc - Global Village
Burgess Home Health/Hospice
Calvin Community Assisted Living
Camp Albrecht Acres of the Midwest
Camp Courageous of Iowa
Camp High Hopes
Capstone Behavioral Healthcare
Care At Home Iowa
Care Initiatives, Inc. (includes Avoca Lodge, Estabrook Lodge, Valley Lodge, Dunlap AL, Lamoni AL, Odebolt AL, Panora AL)
Caregivers of Chariton (formerly Circle of Friends Home Care)
Caring for People of Omaha
Caring Hands & More LLC

Provider Name
Caring Hearts of West Central Iowa
Carroll Area Nursing Service
CCCPCA Family Resource Center (Carroll County Council for the Prevention of Child Abuse dba CCCPCA Family Resource Center)
Cedar Valley Community Support Services
Center Associates
Center for Active Seniors
Centerville Community Betterment, Inc.
Central Iowa Residential Services Incorporated (CIRSI)
Charter Senior Living Sioux City, LLC dba Emeritus at Northpark Place
Chickasaw County Public Health and Home Care Services
ChildServe Community Options and ChildServe Homes
Choice Employment Services, LLC
Choice Inc.
Christian Opportunity Center
Circle of Life Rehabilitation Services
Clarence Assisted Living
Clearview Estates
Clearview Home
Client Community Services Inc
Clover Ridge Place Retirement Community (Ehlers Lane)
COBBLE CREEK ASSISTED LIVING (And Cobble Creek Homes)
Cobblestone Court Assisted Living
Cocojaydy Support Care Services
Comfort Care Medicare, Inc.
Comfort Keepers
Community Adult Residential Environment (CARE A & B)
Community Based Services of Bremer County
Community Care of Knoxville
Community Living Services
Community Support Advocates, LLC
Companion Care QC LLC dba Home Helpers
Comprehensive Systems, Inc.
Concerned, Inc.
Connections Area Agency on Aging/ Southwest 8 Senior Services
Corridor Crossing Place (LAN Silver Pines)
Counseling and Family Centered Services, Inc/Kimberly Conrad PLC
Counseling Associates Inc
Country Meadow Place / Willow Pointe
Country Side Estates
Country View Estates, Inc.
County of Warren dba Warren County Health Services
Courtyard Estates (and Abilt Holdings Cedar Pointe LLC)
Cozy Corner Adult Daycare

Provider Name
Creative Community Options dba Candeo
Cresco Assisted Living
Crossroads, Inc. Senior Resources ADC
Darrell E. Davis Adult Day Center
DAVENPORT LUTHERAN ASSISTED LIVING
DB Cares dba Debra Carroll-Jones
Delaware County Community Life
Developmental Ambassadors of Services and Health
Dignity Care Group, Inc.
Discovery Living, Inc
Divine Touch of Iowa
Duncan Heights, Inc
Easter Seals Iowa
Eastern Star Masonic Home RCF/ Courtyard Terrace AL
Edencrest Beaverdale
Edencrest at Green Meadows (Formerly Green Meadows Senior Housing)
Edencrest at Riverwoods
Edencrest at Siena Hills
Edencrest at The Legacy
Ellen Kennedy Living Center
Elmwood PE, LLC
Embrace Iowa Inc.
Emeritus at Northpark Place
Emerson Point
Emery Place
Equality Through Community
Estherville Assisted Living Windsor Manor
Evergreen Estates I Evergreen Estates II Evergreen Estates III
Everlasting Home Healthcare, LLC
Exceptional Opportunities, Inc.
Exceptional Persons, Inc
Eyerly Ball CMH; "Golden Circle Behavioral Health Eyerly-Ball Community Mental Health Services- includes: Francis House, Cummins House, Residential Services, Senior Outreach Counseling"
Fairbank Assisted Living Center, Inc. / Parkview AL
Faith & Family Care Inc.
Families First Counseling Services
Families Inc
Family Care Solutions LLC
Family Solutions Services 1 Inc
Family Ties of Iowa

Provider Name
Family Wellness Associates
Fieldcrest Assisted Living
First Resources Corporation
First Vision Health Care
FOCUS - Family Options & Community Supports Inc. DBA Iowa Focus
Forest Plaza Assisted Living
Fountain View Assisted Living
Fox Run Assisted Living & Northern Hills Assisted Living DBA Heritage Communities
Franklin County Home Care Service
Friends Forever Social Education Center
Friendship Ark, Inc.
Friendship Haven
Full Circle Services Inc.
Garden View Place
Garnett Place Retirement Community
Generativity DBA The Lakeside Village
Glenwood Resource Center DBA Family Support & Outreach Services
Golden Angel Corporation
Golden Dreams Homecare, L.L.C.
Golden Heart Senior Care
Golden Horizons of Ida Grove (KC Companies of Ida Grove, Inc. dba GOLDEN HORIZONS OF IDA GROVE)
Good Samaritan Society Home Care- Indianola
GOOD SAMARITAN SOCIETY-TIMBER RIDGE
Good Shepherd dba Cornerstone Assisted Living Kentucky Ridge Assisted Living
Goodwill Industries of Central Iowa
Goodwill Industries of Northeast Iowa, Inc.
Goodwill Industries of the Heartland
Goodwill of the Great Plains (Goodwill Industries dba Wall Street Mission (Goodwill of the Great Plains))
GRAND HAVEN & River Bend Callahn Construction
Great River Home Health Care and Hospice
Greenbelt Home Care
Greenfield Manor
Guardian Care of Iowa
Hammond Center/St.Frances Manor
Handicapped Development Center
Hand-in-Hand
Hands Up Communications
Happy Home Respite Services
Harrison County Homemaker Agency
Heartland Health Management dba The Willows
Heartland Senior Services

Provider Name
Heights Home Health Inc.
Help At Home, Inc.
Heroes for Home Care
Highland Ridge (Williamsburg Retirement Community)
Hillcrest Family Services
Hills & Dales
Holstein Senior Living
Home Care Services of Boone County Hospital DBA William Beckwith Family Adult Day Services
Home Sweet Home Care, Inc.
Homecare Options, Inc.
Homestead of Knoxville-Includes Albia, Centerville, Chariton, Creston, Mason city, Osceola and Oskaloosa
Hope Community Living of Iowa Inc
Hope Haven Area Development Center Corporation
Hope Haven Inc.
HOPE Inc. (Honoring Opportunities for Personal Empowerment)
Horizons Unlimited of PAC Inc.
Howard Center Inc.
Humboldt County Public Health
Imagine the Possibilities
Imprints LLC DBA Tandem Services
Inclusion Connection
Infinite Angels HHC
Innovative Industries, Inc.
Insight Partnership Group, LLC
Intra-National Home Health Care
Invigorating Services
Iowa Family Assistants LLC
Iowa Family Services
Iowa Home Care LLC
Iowa Institute of Philosophy dba Intention Inc.
Irving Point
J & J Enterprises dba Comfort Keepers
Jem Enterprises of Iowa
Julian Unleashed, Inc.
Keelson Harbour
Kensington Place Assisted Living
Keokuk Village Drive LLC dba River Hills Village
Keystone Home Health
Kingston Court Assisted Living
Lakes Life Skills LLC
Lakeside Lutheran Home
Lakeview Village

Provider Name
L'Arche Clinton / Arch, Inc
Lawton Senior Living
Lee County PHN Service
Liberty Square Care Center LLC DBA Spring Harbor Residential Services
Liebe Inc. Cedar Vale Assisted Living Whispering Willow Assisted Living
Life Connections, L.C.
Life Skills Training Center, Inc.
LifeWorks Community Services / Iowa Central Industries
Limitless Potential, Inc. (LPI)
Lincolnway Villa Assisted Living
Lincolnwood Assisted Living
Link Associates
Louisa County PHN Service
LovingTouch Inc.
Lutheran Home Communities (including Lutheran Home Apartments & Lutheran Home Health Agency)
Lutheran Homes dba Valley View Manor Lutheran Living Senior Campus
Lutheran Services in Iowa, Inc.
Madison Co Public Health/ Lifeline
Maggie's House Assisted Living--Living Longer Strategies, LLC
Mainstream Living, Inc.
Manning Senior Living
Maple Crest Assisted Living/Colonial Manor
Maple Grove Senior Living
Maxim Healthcare Services
Mayflower Homes, Inc.
Mayor's Youth Empowerment Program (MYEP)
Mediapolis Care Facility
Mercy Home Health Care
Mercy Medical Center and Home Care
MercyOne Waterloo Home Health
METHODIST MANOR RETIREMENT COMM
Mid-Iowa Workshops Inc (MIW INC.)
Mid-Step Services, Inc
Mobile Nursing Services, Ltd.
Monroe County Professional Management
Mosaic
Mosaic in Northern Iowa
Mosaic of Des Moines
Mosaic Osceola DBA Mosaic in South Central Iowa
Mount Ayr Health Care Center
Neema Corporation

Provider Name
NeuroRestorative Iowa
New Aldaya Lifescapes/Cedar Falls Lutheran Home/Bryhl Assisted Living
New Beginnings Counseling Service
New Choices Inc
New Hope Village
New Horizons Adult Day Center
New Horizons Family Enhancement Center, Inc.
New Insights Community Services
New Perspectives, Inc.
New Venture Group Home
Newton Village
Next Step Counseling Services INC
Nishna Productions, Inc.
North Star Community Services, Inc.
Nurse in the House, Inc. (Fairfield)
Oakhill AL Corp
Oakland Heights / Oakland Manor DBA Oakland Healthcare Management, LLC
OMNI Behavioral Health dba Omni Inventive Care
On With Life Community SVCS
One Vision (formerly known as Opportunity Village)
Opportunities Unlimited
Opportunity Homes Inc
Optimae Lifeservices
Options of Linn County
Orange City Home Health & Hospice
Oscar Home Health
Park Place RCF/ Sunshine Homes Inc. DBA Park Place
Parker Place Retirement Community
Partnership for Progress, Inc.
Pathway Living Center, Inc.
Peace Tree Community Living
Phippsburger Inc DBA Accessible Home Health Care of Des Moines
Pine Acres Assisted Living
Pinnacle Health Facilities/Arbor Heights
Pioneer Place
Plains Area Mental Health INC
Pleasant View Care Center / Whiting Commercial
Prairie Hills Des Moines (ARHC PHDESIA01 TRS LLC)
Prairie Hills Independence
Prairie Hills Tipton (ARHC PHCTNIA01 TRS, LLC)
Prairie View Management, Inc.
Premier Payee
PRIDE GROUP @ LE MARS / Pride Group Inc / Plymouth Life
Prime Care LLC / Prime Living

Provider Name
Progress Industries
Progressive Community Network
Pure Health Services
QHC Madison Square, LLC
QHC Villa Cottages, LLC
Quad Cities Service Providers
Quality Choices, Inc.
Ragtime Industries
Reach For Your Potential, Inc
Recover Health
Reflections Assisted Living and Silver Pond Assisted Living Parkview Healthcare Management dba
Regency Assisted Living
REM- Region 2- Hiawatha
REM- Region 3- Davenport
REM- Region 4- Keokuk
REM- Region 5 Statewide DH
REM-Region 1- Council Bluffs
Resourceful Unlimited
Ringgold County Group Home
Ringgold County Supportive Services
RISE, LTD
River Bend Assisted Living - Combined with Grand Haven Callahan Construction- see note section.
River Living Center Tower Living Center
Riverside Senior Living
RK Moser LLC dba Stoney Brook Village
Rock Rapids Premier Estates, LLC
Roots & Company
Rotary Senior Living
Rural Employment Alternatives, Inc. (REA)
Ruthven Community Care center
S & J Services / Comfort Keepers
Salvation Army Adult Day Health Center (Salvation Army ADHC)
Sass.illy Endeavors / Comfort Keepers
Scenic Acres
Seasons Center (NW Iowa Mental Health Center (Iowa Mental Health Center) dba Seasons Center)
Self-Reliance Inc.
Senior Care of Iowa at Home
Senior Suites of Urbandale
Shellsburg Associates, Inc. (DBA Rock Ridge Residential)
Silver Palms Heartland Health Management Silver Palms

Provider Name
Simple Life, Inc.
Sioux Center Health (Sioux Center Health Franken Manor/Crown Point AL/Comm Health & Enrich Serv Chears / Sioux Center Comm Hosp)
Skyline Center, Inc.
South Central Home Health Care Inc
South Dakota Achieve
Southern Iowa Independent Living
Southern Iowa Resources for Families
Southwest Iowa Home Health
St. Anthony Home Health Agency
St. Lukes Home & Service
Stepping Stone Family Services
Successful Living
Summit House Assisted Living
Sunlight Support, Inc.
Sunnybrook Home Care, Inc.
Sunrise Villa Assisted Living
Sunset Park Place
Support Services of South Central Iowa
Symmetry Health
Systems Unlimited Inc.
Tailored Living
Tama Co Public Health and Home Care
Tanager Place
Tappe & Sanchez Support Services
TASC Inc.
Terrace Park Assisted Living
The Arc of East Central Iowa
The Arc of Southeast Iowa
The Cedars of Madrid Homes DBA Cedars of Madrid
The Community Support Network Inc.
The Gardens at Cherokee (The Gardens VL Cherokee DBA Gardens at Cherokee)
The Gardens at Jefferson (VL Jefferson, LLC dba The Gardens Retirement Community)
The Kensington
The Larrabee Center
The Meadows (AKA Neighborhood Retreat or Good Neighbor Society)
The Meadows Assisted Living
The New Homestead/ Homestead Acres Assisted Living DBA Homestead Acres
The Respite Connection, Inc.
THE ROSE OF AMES LIMITED PARTNERSHIP, The Rose of Waterloo, The Rose of Dubuque, The Rose of Des Moines, The Rose of east Des Moines, The Rose of Council Bluffs
The Spectrum Network
The Views (Meadowview Memory Care and Ridgeview Assisted Living)

Provider Name
The Village Community
Therapy Solutions, Inc.
Thornton Heights Assisted Living / Lansing Housing Corp
Timberland Village / Bethany Life Communities / Cedar Place AL
TLC In-Home Care Services
To the Rescue
Traditions of West Union LLC (Traditions at West Union DBA: Copper Creek Senior Living) Copper Creek Memory Care
Trivium Life Services
Turner Pointe Assisted Living
Tynique's Rose Garden
Ultimate Nursing Services of Iowa, Inc dba Universal Pediatrics
UNI-Hope Life Skills and Services
United Presbyterian Home
Unity Point At Home - Intrust (Iowa Health Home Care dba Intrust)
Unlimited Abilities
Unlimited Services, Inc.
Van Buren Job Opportunities
Vera French Pine Knoll Residential
Veridian Fiscal Solutions (CCO FMS)
Via of Carlisle Care Assisted Living
Vibrant Home Care (SCL)
Village Assisted Living Inc - DSM
Village Northwest Unlimited
Village Ridge (AKA Tapestry Senior Living of Marion)
Vintage Park Apartments Assisted Living
Visiting Nurses Assoc of Johnson County
Vita Health Services
Vocational Development Center, Inc. (VODEC)
Warren County Health Services
Waubonsie Mental Health Center
WCDC, Inc.
Webster City IA Assisted Living Tenant LLC dba Windsor Manor
WEL- Life at Alta
WEL- Life at Spirit Lake
WEL-Home Health of Logan/ Sgt. Bluff/Red Oak
Wellington Place Assisted Living
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
Wesley Retirement Services , Inc dba WesleyLife (includes Wesley Acres Central, Wesley Acres John's Harbor, Halcyon House, Heritage House, The Cottages, Edgewater, The Village, Wesley Park Centre, Brio of Johnston)

Provider Name
Western Home Communities dba Stanard Family Assisted Living Western Home Communities dba Windhaven Assisted Living
Westside Assisted Living Suites
White Oak Estates Independent, Inc
Windsor Manor - Nevada
Windsor Manor Assisted Living DBA Windsor Manor
Windsor Manor Assisted Living of Indianola
Windsor Manor Grinnell/Grinnell Assisted Living/Grinnell Staffing LLC
Windsor Manor Of Algona
Windsor Manor Vinton
Woodward Resource Center
Woodward Youth Corporation dba Woodward Community Based Services
Youth Homes of Mid-America