



Iowa Home and Community-Based Services Settings Statewide Transition Plan

1.0: Introduction

Federal regulations that became effective on March 17, 2014 define the settings in which it is permissible for states to pay for Medicaid Home and Community-Based Services (HCBS). The purpose of these regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals who do not receive HCBS. The regulations also aim to ensure that individuals have a free choice of where they live and who provides services to them, as well as ensuring that individual rights are not restricted. While Medicaid HCBS has never been allowed in institutional settings, these new regulations clarify that HCBS will not be allowed in settings that have the qualities of an institution.

Since the inception of the Medicaid program in 1965, care provided in Skilled Nursing Facilities has been a covered service. With the addition of certain optional services in 1972, many states have covered services in other institutional settings such as Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID). During this time, institutional care was often the only choice for persons with disabilities. In 1981, Section 1915(c) of the Social Security Act was established, which allowed states the opportunity to provide optional Medicaid services to individuals with disabilities in their own homes and communities as an alternative to institutional care.

Since that time, HCBS has been provided in a wide variety of settings, many of which are truly integrated in the community. However, some of these settings may still retain, or appear to retain, the qualities of institutional care. In order to ensure that HCBS programs offer a true alternative to institutions, CMS has issued regulations to better define settings in which states can provide Medicaid HCBS.

The rule sets the expectations for settings in which HCBS can be provided. The overarching theme is stated in the rule:

“The setting is integrated in and supports 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.”

The rule also requires that the setting:

- Is selected by the individual from options that include non-disability specific settings and options for private units. Individuals must also have choice regarding the services they receive and by whom the services are provided.
- Ensures the individual right of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom they interact.

When a residential setting is owned or controlled by a service provider, additional requirements must be met:

- At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.
- Each individual has privacy in their sleeping or living unit. This includes having entrance doors to the member's living and sleeping unit which can be locked by the individual with only appropriate staff having keys; individuals having a choice of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.
- Individuals have the freedom and support to control their own schedules and activities, including having access to food at any time, and having visitors of their choosing at any time.

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

In addition to setting out the above qualities of HCBS settings, the rule also specifies certain settings in which HCBS cannot be provided. This includes settings that have always been statutorily excluded such as hospitals, nursing facilities, ICF/IDs, or institutions for mental disease (IMDs). However, the rule also goes a step further and describes settings that are presumed to have the qualities of an institution:

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

Any settings that fit this description are presumed to be institutional in nature and HCBS services cannot be allowed in the setting unless the state can demonstrate to CMS through a “heightened scrutiny” process, that the setting does not have the qualities of an institution. Based on information submitted by the state and input from the public, CMS will determine whether or not a setting meets the qualities for being HCBS.

2.0: Iowa's Statewide Transition Plan

2.1: Public Notice and Public Comment Period

A public notice was published electronically January 22, 2016, on the Iowa Medicaid Enterprise (IME) website at: <http://dhs.iowa.gov/ime/about/initiatives/HCBS>. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on January 16, 2016. Notice was also sent to the federally-recognized tribes on January 16, 2016.

The transition plan was posted on the (IME) website at: <https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans>. The transition plan has been available at that location since February 1, 2016. Public comment was taken from February 1, 2016 through March 2, 2016. The transition plan was available for non-electronic viewing in any of the 99 DHS offices across the state for persons who may not have internet access.

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

2.1.1: Summary of Comments Received

The IME received comments from 11 individuals or entities during the open comment period including family members, advocacy organizations, provider associations, case managers and providers.

The majority of questions and comments received focused on:

- The assessment, review and compliance process that will be used by the department to identify and evaluate residential and non-residential settings for compliance with the HCBS setting rule
- Clarification on the criteria to be used in the assessment of settings process
- Request for additional guidance from the department on rules for HCBS setting implementation
- Increased opportunity for stakeholder input in the setting assessment process
- The need for a six month delay in the rules making process to allow for a more fulsome review of current rules regarding compliance with settings

Below is the department response to the general summary of comments followed by six specific changes made to the STP based on the comments received.

General response:

The department is taking a multifaceted approach to the assessment of HCBS settings. This includes a systemic review of the State's rules and policies and a high-level settings analysis. Other avenues for assessment will include evaluating settings through the existing HCBS quality assurance provider self-assessment process and onsite review process; onsite assessments by community-based case managers; and

monitoring of Iowa Participant Experience Survey (IPES) results for member experiences.

The department contracts for the HCBS Quality Oversight Unit (QOU) function through a request for proposal process. The HCBS QOU is the single entity that is responsible for all quality oversight activities, including the review and assessment of HCBS settings. While there may be multiple entities that will be responsible for gathering HCBS settings information and data, such as community based case managers, the HCBS QOU is responsible for coordinating quality assurance activities for the department. Currently the department contracts with Telligen, Inc. to conduct the quality oversight activities of the HCBS and Habilitation programs.

The HCBS QOU uses the HCBS Provider Self-Assessment tool as the foundation for quality assurance activities. The Provider SA is an annual attestation tool completed by HCBS Medicaid waiver providers. Section III. Requirement B., of the SA was updated in 2015 to include the CMS settings final rule indicators. Providers are required to attest (yes or no) to each of the setting indicators on the SA and are required to have documentation to support that systems are in place to support the indicator. Each provider SA is reviewed by the regional HCBS QOU specialist assigned to the provider.

The SA is incorporated into the four quality oversight review processes conducted by the HCBS QOU; periodic, focused, targeted and certification reviews.

Periodic Reviews: Providers are reviewed on a random basis. The selection process occurs on a five-year cycle. During the review process providers are held accountable for responses from the self-assessment, Iowa Administrative Code, Iowa Code, and Code of Federal Regulations.

Focused Reviews: Providers are reviewed on a random basis. The selection process occurs on a five-year cycle. The focus subject is determined annually and based on historical data. The SFY17 focus topic HCBS setting readiness.

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

Certification Reviews: Certification reviews occur 270 days after initial enrollment as an HCBS certified provider. Subsequent certification reviews are determined by the results of the 270 day review and level of certification the provider receives.

A quality oversight process of discovery, remediation and improvement is used to assure compliance with all rules of the HCBS and Habilitation programs. When a compliance issue is identified, the provider is required to develop a corrective action plan (CAP) to address the issue. The CAP is submitted to the HCBS QOU Regional Specialist for review and acceptance. Once a plan is accepted, a compliance review is scheduled and conducted within 60 days to assure that the activities identified in the CAP are being implemented. Providers that demonstrate compliance will be identified as such and ongoing quality monitoring activities are implemented for continued compliance. Providers unable to develop and implement an acceptable CAP to address the specific issues may have sanctions imposed. Sanctions may include

probation, suspension or termination from the Medicaid program. Any adverse action taken by the HCBS QOU may be appealed by a provider.

For validation of HCBS settings, the various assessment processes identified in the STP are methods of discovery. The final outcome of the assessment and review process of HCBS settings is for the department to determine whether a specific setting meets the HCBS settings rule. Providers are required to have documentation to support the attestations identified on the annual self-assessment. During the HCBS settings review process, if a provider is found to be out of compliance with the rules, the HCBS Quality Oversight Unit will work with the provider to develop a CAP to come into compliance. Once a plan is accepted, a compliance review is scheduled and conducted to assure that the activities identified in the CAP are being implemented. Providers that demonstrate compliance with the settings rules will be identified and ongoing quality monitoring activities (periodic, focused, targeted, certification reviews) are implemented for continued compliance. If the corrective action plan is either not accepted or a compliance review finds that a provider has not implemented the approved plan, the provider will be notified that HCBS funding is not available to waiver recipients receiving services in that setting/location. This does not mean that services cannot be provided in that location, but rather that HCBS funding is not available to members to fund services at that location until the provider shows compliance with the with the setting rules.

When service locations are found to be out of compliance with the rules and a provider is unable to become compliant through a CAP, the department believes that most members will secure a new provider in a location that meets the settings standards or will find alternative HCBS services in integrated settings to meet their needs. But as noted in some of the public comments received on the STP, there may be some members that like the services they are receiving and will want to continue to receive services in the non-compliant location. One of the foundations of person centered planning is member choice of providers and services received. A member may choose to receive services in non-compliant settings, but HCBS funding will not be available.

Unless the site specific setting is a hospital or medical institution that does not meet setting criteria, the experience of the member receiving services in that location is the primary defining element of the HCBS final rule.

A few comments received requested a delay in the rule making process to allow a more fulsome review of the current administrative rule. The department believes the subject matter experts that reviewed and analyzed the rules for compliance were accurate in the findings and as such, will not delay the rule process. For clarification, the department has added rules summary information to section 2.3.1.1 *Administrative Rules, below*.

Additional comments were received asking for clarification of the some STP content, correction of errors and the need for increased stakeholder input. Based on these comments, the following changes were made to the STP. When reviewing the changes a word strikethrough (e.g., ~~strikethrough~~) identifies language that is removed and an underlined word is the added language:

1. Lockable units (page 2 of the STP):

When a residential setting is owned or controlled by a service provider, additional requirements must be met:

- At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.
- Each individual has privacy in their sleeping or living unit. This includes having entrance doors to the member's living and sleeping unit which can be locked by the individual with only appropriate staff having keys; individuals having a choice of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.
- Individuals have the freedom and support to control their own schedules and activities, including having access to food at any time, and having visitors of their choosing at any time.

2. STP updates, information, and announcements.

The following info was added to page 31 of the STP.

14	<u>Ongoing information, updates and announcements</u>	<u>Ongoing updates and information about the implementation of the Iowa statewide transition plan will be available on the department website at:</u> http://dhs.iowa.gov/ime/about/initiatives/HCBS	4/1/16	3/17/19
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3. Stakeholder input.

The following info was added to page 31 & 32 of the STP.

15	<u>Ongoing stakeholder input from members, families, advocates, providers and other interested parties.</u>	<u>The department shall seek stakeholder input and feedback on the implementation of the statewide transition plan. At a minimum, the department shall provide opportunity for stakeholder input every six months through statewide webinars, focus groups or other means of input</u>	4/1/16	12/31/18
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As follow up to the HCBS Settings survey (ID # 3 above) sent to providers, a focus group of providers and HCBS Quality Assurance staff was gathered for three meetings and one conference call (ID #4). The intent of the focus group was to gather input from

HCBS providers and HCBS Quality Oversight staff and to develop a set of indicators that identify what services would look like in HCBS settings. The outcome of this focus group was the creation of four indicators for use by providers and quality oversight staff for development, provision, and oversight of HCBS services to assist providers to meet HCBS Settings requirements. Examples of evidence to support the implementation of the indicators were also developed. These draft indicators will receive additional stakeholder input from members and advocates prior to implementation.

4. Technical Errors

The following changes are made to reflect errors in the STP:

p. 30. Community-based case managers from Iowa's ~~four~~ three MCOs will perform onsite reviews of residential HCBS providers. Providers will be randomly selected based on a statistically valid sample of members taken at the 95% confidence level.

p.3-4. Brain Injury Waiver (CMS Waiver # IA.0299) – offers services for those who have been diagnosed with a brain injury due to an accident or illness and who meet the nursing facility, skilled nursing facility, or ICF/ID level of care. Members must be at least one month of age ~~but less than 65 years of age for this waiver.~~

5. Provider owned and controlled settings.

The language for provider owned and controlled settings listed on page 23 were used in the 2014 self-assessment in which providers responded and baseline data was gathered. As such, the language will not be changed on the STP. However, the definition of provider owned and controlled settings will be updated on the 2016 self-assessment to reflect the CMS guidance (below) and will be used in the assessment and review process moving forward:

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

6. Summary of comments received.

Per CMS, the STP to be submitted on April 1, 2016, will only include a summary of the comments received, and not the full list of comments received or the department's response in full. To facilitate transparency and goodwill, the department will post all comments received and responses to comments that have been developed by the department. The DHS website: <http://dhs.iowa.gov/ime/about/initiatives/HCBS> will be updated under “News and Announcements”

2.2: HCBS Programs Included in the Transition Plan

This statewide transition plan applies to all HCBS programs within the state, including Iowa's 1915(i) State Plan HCBS program known as HCBS Habilitation Services and the seven 1915(c) HCBS Waiver programs, 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 – offers services and supports for Iowans with the functional impairments typically associated with severe and persistent mental illnesses. There are no age limitations for this program.

AIDS/HIV Waiver (CMS Waiver # IA.0213) – offers 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) – offers services for those who have been diagnosed with a brain injury due to an accident or illness and who meet the nursing facility, skilled nursing facility, or ICF/ID level of care. Members must be at least one month of age.

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

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

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

Intellectual Disability Waiver (CMS Waiver # IA.0242) – offers 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) – offers 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.

2.3: Assessment and Remediation Strategies

Iowa is taking a multifaceted approach to assessment. This includes a systemic review of the State's rules and policies and a high-level settings analysis. Other avenues for assessment will include evaluating settings through the existing HCBS quality assurance provider self-assessment process and onsite review process; onsite assessments by community-based case managers; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences. These activities are described in more detail in the "Site-Specific Assessment Process" section below.

Iowa's remediation process will capitalize on existing HCBS quality assurance oversight processes including a requirement for submission of a corrective action plan that will detail remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain remediation requirements for providers to become compliant. Iowa will provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings in a timely manner may be subject to sanctions. These activities are described in more detail in the "Site-Specific Assessment Process" section below.

Iowa moved to a managed care service delivery system that on April 1, 2016. The managed care contracts between the state and the selected MCOs include provisions that require the MCOs to provide training on person centered planning and HCBS setting criteria. All HCBS providers that contract with MCOs must first be enrolled with the IME Provider Services unit. All providers enrolled with the IME Provider Services unit will be initially and regularly assessed for compliance with the HCBS settings standards. As the gatekeeper of enrolled providers, the IME will communicate with each MCO when providers do not meet the setting criteria and assure services are not provided with MCO funding.

2.3.1: Systemic Assessment: Review of Standards

A comprehensive review of state administrative rules, Medicaid policy manuals, and other state standards such as provider agreements has been conducted.

2.3.1.1 Administrative Rules

The following Medicaid rules were reviewed. The results shown here indicate whether the rule supported the federal regulations, conflicted with the federal regulations, or was silent in respect to the regulations.

The Iowa Administrative Code applicable to the HCBS and Habilitation programs includes:

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

When analyzed as a whole, the state believes that the four IAC rule chapters support a HCBS member to received services in community based integrated settings. The state believes the rules support a member to have choice and control in the services and supports they receive. As such, the state’s analysis of the administrative rules identify that collectively, the majority of the rules support the federal regulations. The state also acknowledges that the rules of the HCBS program have been in place for many years with periodic updates that reflect the addition of new services, new waiver programs and the Habilitation programs, and program evaluation that require policy change. In the analysis below it has been identified that additional rule changes will be necessary to update the Iowa administrative code to fully reflect and comport with the new federal regulation around integrated community settings and person centered planning. Specific rule language is identified in the overall conclusion summary at the end of section 2.3.1.1 beginning on page 44

Below is a high level review of the individual IAC chapters. A more detailed crosswalk follows this summary.

Medicaid Administrative Rules Summary of Results	
Rule	Result
441—IAC—54 : Facility Participation	Possible conflict
441—IAC—77.25 : HCBS Habilitation Services Conditions of Participation for Providers	The majority of rules support; additional rule language needed to clarify CMS setting regulations
441—IAC—77.30 : Health and Disability Waiver Conditions of Participation for Providers	The majority of the rules support; additional rule language needed to clarify CMS setting regulations
441—IAC—77.33 : Elderly Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations

441—IAC—77.34 : AIDS/HIV Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.37 : Intellectual Disability Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.39 : Brain Injury Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—77.41 : Physical Disability Waiver Conditions of Participation for Providers	Silent
441—IAC—77.46 : Children’s Mental Health Waiver Conditions of Participation for Providers	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.27 : HCBS Habilitation Services Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.34 : Health and Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.37 : Elderly Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.38 : AIDS/HIV Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.41 : Intellectual Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.43 : Brain Injury Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.46 : Physical Disability Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—78.52 : Children’s Mental Health Waiver Amount, Duration and Scope of Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—79 : Other Policies Relating To Providers of Medical and Remedial Care	Silent

441—IAC—83 : Medicaid Waiver Services	The majority of rules supports; additional rule language needed to clarify CMS setting regulations
441—IAC—90 : Targeted Case Management	The majority of rules supports; additional rule language needed to clarify CMS setting regulations

The matrix below provides a more detailed crosswalk from the federal regulations to the state administrative rules and provides the status of actions needed for any gaps that were identified. The IAC rules listed below are paragraphs and subparagraphs taken from a larger chapter of rules that are specific to individual HCBS waivers and the Habilitation program. These paragraphs and subparagraphs identify specific services, provider criteria, and waiver eligibility requirements and are used as examples of support of the federal requirements for settings and person centered planning. While the state believes that the identified paragraphs and subparagraphs support the federal requirements, there are other rule paragraphs and subparagraphs within the larger rule chapter that infers or assumes support of the federal rules, but may not clearly support the federal requirements. For example, home and vehicle modification, specialized medical equipment, or transportation services assumes or infers that services are provided within the members home and community but do not specifically states that services are to be provided in integrated community settings. For this reason, the state has determined that the majority of the rules support the federal requirements for settings and person-centered planning.

The rule analysis below identifies in the “Action Needed” column that additional rule language is needed to clarify CMS setting regulations and assure that the entirety of each applicable chapter of the IAC will fully reflect and comport with the new federal regulation around integrated community settings and person centered planning. The state will update all IAC rule chapters applicable to the HCBS Waiver and Habilitation programs. The specific rule language that will be used is identified in the overall conclusion summary at the end of section 2.3.1.1 beginning on page 44

Please note that the links to rules in this matrix open only to the relevant rule; it is not possible to link directly to the specific subrule or paragraph. In most instances, specific rule text is included as an example of support to the federal requirement.

Federal Requirement: Settings are integrated in and 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.			
State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, home-based habilitation services, community inclusion is addressed in 441—78.27(7)“a” ; and for day habilitation services in 441—78.27(8)“a” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: Per Iowa administrative Code (IAC) 441- CH 78, page 71 states:

Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan”.

IAC rules for day habilitation (441-78.27(8)b., page 72) states:

Day Habilitation services shall take place in a nonresidential setting 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. Day habilitation services provided in RCF setting would require a heightened scrutiny review to assure services provided are integrated into community

See attachment “B” for additional text from the Iowa Administrative Code in support of the state’s determination that the Habilitation rules support the CMS setting regulations.

For Intellectual Disability (ID) Waiver supported employment, respite, and supported community living (SCL) services, standards supporting these requirements are addressed in [441—IAC—77.37\(2\)](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

Summary: This IAC rule section identifies 19 value based outcomes that support the rights and dignity of members receiving services. Value based outcomes such as “Consumer have privacy”, “Consumer make informed choices about where and with whom they live.”, or “Consumers are part of community life and perform varied social roles.”, are included. The 19 outcomes assist case managers and services providers to identify what is import to the member and then develop and implements services and supports based on how the outcome is defined by the individual member. All 19 outcomes identify a full spectrum of rights and dignities of members to be identified and supported. The outcomes include

77.37(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

- a. (Outcome 2) Consumers are valued.
- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers’ money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer’s living environment is reasonably safe in the consumer’s home and community.
- r. (Outcome 19) The consumer’s desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

For ID Waiver SCL services, community inclusion is addressed in [441—IAC—78.41\(1\)”a”](#) and for day habilitation services in [441—IAC—78.41\(14\)”a”](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

<p><u>Summary:</u> This IAC rule section identifies that: 78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services. Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.</p>			
For ID Waiver residential-based SCL for children, these are addressed in 441—IAC—77.37(23)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> This rule section requires a provider to establish standards for the rights and dignity of children that are age-appropriate. The outcomes assist case managers and services providers to identify what is import to the member and then develop and implement services and supports based on how the outcome is defined by the individual member. The standards for rights and dignity include:</p> <p>2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:</p> <ul style="list-style-type: none"> ● Children, their families, and their legal representatives decide what personal information is shared and with whom. ● Children are a part of family and community life and perform varied social roles. ● Children have family connections, a social network, and varied relationships. ● Children develop and accomplish personal goals. ● Children are valued. ● Children live in positive environments. ● Children exercise their rights and responsibilities. ● Children make informed choices about how they spend their free time. ● Children choose their daily routine. 			
For the ID Waiver supported employment service, opportunities to pursue competitive work in integrated settings is addressed in 441—IAC—78.41(7) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: Individual supported employment services are services provided to, or on behalf of, a member that enable them to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce. The IAC rules identify that individual supported employment services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

On May 4, 2016 the state implemented new rules for supported employment for the ID, BI and Habilitation. The rules implemented changes to the provider qualifications, service definitions and reimbursement methodologies for HCBS Prevocational and Supported Employment services and will bring HCBS prevocational and employment services into compliance with the definitions and service structure as provided by the Centers for Medicare and Medicaid Services (CMS) in their 2011 bulletin and the 2015 1915 (c) Technical Guide. See attachment “B” for the text of the new SE rules.

For Brain Injury (BI) Waiver supported employment, behavioral programming, and supported community living (SCL) services, standards supporting these requirements are addressed in 441— IAC—77.39(2) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This IAC rule section identifies 19 value based outcomes that support the rights and dignity of members receiving services. Value based outcomes such as “Consumer have privacy”, “Consumer make informed choices about where and with whom they live.”, or “Consumers are part of community life and perform varied social roles.”, are included. The 19 outcomes assist case managers and services providers to identify what is import to the member and then develop and implements services and supports based on how the outcome is defined by the individual member. All 19 outcomes identify a full spectrum of rights and dignities of members to be identified and supported. These include:

77.39(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

- a. (Outcome 2) Consumers are valued.
- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m.(Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers’ money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer’s living environment is reasonably safe in the consumer’s home and community.
- r. (Outcome 19) The consumer’s desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

For BI Waiver case management services, choice and community inclusion are addressed in 441—IAC—78.43(1)”b” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: 78.41(2) states:

Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

For BI Waiver SCL services, community inclusion is addressed [in 441—IAC—78.43\(2\)"a"](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

Summary: This IAC rule section identifies: that SCL services:

"a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

For the BI Waiver supported employment service, opportunities to pursue competitive work in integrated settings is addressed in [441—IAC—78.43\(4\)](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

Summary: Individual supported employment services are services provided to, or on behalf of, a member that enable them to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce. The IAC rules identify that individual supported employment services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

On May 4, 2016 the state implemented new rules for supported employment for the ID, BI and Habilitation The rules implemented changes to the provider qualifications, service definitions and reimbursement methodologies for HCBS Prevocational and Supported Employment services and will bring HCBS prevocational and employment services into compliance with the definitions and service structure as provided by the Centers for Medicare and Medicaid Services (CMS) in their 2011 bulletin and the 2015 1915 (c) Technical Guide. See attachment “B” for the text of the new SE rules.

<p>For the PD waiver the rules in IAC 441- 77.41(249A) https://www.legis.iowa.gov/docs/ACO/chapter/441.77.pdf address provider qualifications for HCBS PD Waiver services.</p>	<p><u>Silent</u></p>	<p><u>Rule Change (see overall conclusion at end of this section</u></p>	<p>See section 2.3.5</p>
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Summary: IAC Chapter 77 rules address HCBS provider qualifications for each individual HCBS service. HCBS waiver services, like SCL , supported employment (SE), day habilitation, prevocational services, etc., are identified in rule as provided in specific residential or non-residential settings. The rules for these site specific services identify the applicable setting criteria.

The services that are available in the PD waiver and identified in IAC 441-77.41(249A) are CDAC, HVM, PERS, SME, Transportation, and CCO. These services are not site specific and do not require or identify specific residential or non-residential settings in the service descriptions. As such, they are identified as being silent in support of being provided in integrated settings. IAC Ch. 78 rules address specific service components and services delivery criteria. CH 441-78.46(249A) for the PD Waiver rules are addressed in this section (2.3.1.1) of the transition plan and identify that are provided to the member in the least restrictive environment.

<p>For the Children’s Mental Health Waiver, inclusion in community life is addressed in 441—IAC—77.46(1)”c”.</p>	<p>The majority of rules supports.</p>	<p>Additional rule language needed to clarify CMS setting regulations</p>	<p>See section 2.3.5</p>
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This section of the IAC rules identify that Children’s Mental Health providers shall implement outcome-based standards for the rights and dignity of children with serious emotional disturbance. These rights and dignities are identified in CH 77.46(249A) and include:
c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

The outcomes assist case managers and services providers to identify what is important to the member and to develop and implement services and supports based on how the outcome is defined by the individual member.

For HCBS Habilitation Services supported employment services, opportunities to pursue competitive work in integrated settings is addressed in 441—IAC—78.27(10)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: Individual supported employment services are services provided to, or on behalf of, a member that enable them to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce. The IAC rules identify that individual supported employment services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

On May 4, 2016 the state implemented new rules for supported employment for the ID, BI and Habilitation Services. The new rules implemented changes to the provider qualifications, service definitions and reimbursement methodologies for HCBS Prevocational and Supported Employment services and will bring HCBS prevocational and employment services into compliance with the definitions and service structure as provided by the Centers for Medicare and Medicaid Services (CMS) in their 2011 bulletin and the 2015 1915 (c) Technical Guide. See attachment “B” for the text of the new SE rules.

Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

State Rule	Determination	Action Needed	Timeline
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<p>For 1915(i) Habilitation Services, service plan requirements related to needs, choice, and desired individual outcomes are addressed in 441—IAC—78.27(4)“a”.</p>	<p>The majority of rules supports.</p>	<p>Additional rule language needed to clarify CMS setting regulations</p>	<p>See section 2.3.5</p>
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Summary: IAC rules identify that a comprehensive service plan or treatment plan be developed for each member receiving home- and community-based habilitation services based on the member’s current assessment and reflect the member’s desired individual outcomes. The member works with their interdisciplinary team to identify providers and services.

IAC 441-78.27(1) Definitions., identify the following terms and definitions that the state believes supports the intent of individualized services define for the Habilitation program state:

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Case management” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90

“Comprehensive service plan” means an individualized, 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.

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

441-78.27(1)a. defines how service plans are developed

CH 90.5(1) defines CM service plan development. This includes:

“The comprehensive assessment shall address all of the member’s areas of need, strengths, preferences, and risk factors, considering the member’s physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member’s condition.”

“The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member’s legally authorized representative and other sources to choose providers and develop the goals”

The state believes that the above rules identify or directly imply the active involvement of the member as part of the interdisciplinary team to be supported in making informed decisions about services and supports received. The comprehensive service plan identifies all needs of the member and identifies services and supports that can be accessed to meet the needs. The service plan looks for all community supports, not just those available through the Habilitation program. The member is afforded choice in the services and supports available to meet their need.

In situations where the rules do not specifically identify the support of members to be in the center of the person centered planning process, the state will modify existing rules to better clarify the role of the member in directing and selecting services and the support they received to fully engage in the member in the person centered planning process.

<p>For the Health and Disability Waiver, service planning based on individual needs and desires is addressed in 441—IAC—83.2(2)“a”.</p>	<p>Conflicts</p>	<p>Will require IAC rule changes</p>	<p>3/31/17</p>
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Summary: The rule identifies the development and implementation of the of the members comprehensive service plan. Specifically:

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter. The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

The above rule does not fully support person centered planning and the involvement of the member in the person centered planning process. Rules changes are needed to enhance and support the member to be active in directing and selecting services to meet their individual needs.

For the Elderly Waiver, service planning based on individual needs and desires is addressed in 441—IAC—83.22(2)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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- Summary: Identifies the role of the IDT and how to identify the need for services. specifically these rules state:
Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:
- (1) Observable or measurable individual goals.
 - (2) Interventions and supports needed to meet those goals.
 - (3) Incremental action steps, as appropriate.
 - (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
 - (5) The desired individual outcomes.
 - (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
 - (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
 - (8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:
 1. The name of the service provider responsible for providing the service.
 2. The funding source for the service.
 3. The amount of service that the consumer is to receive.
 - (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.
 - (10) The determination that the services authorized in the service plan are the least costly
 - (11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:
 1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
 2. The emergency backup support and crisis response system identified by the interdisciplinary team.
 3. Emergency, backup staff designated by providers for applicable services.

The state believes that the above rules identify or directly imply the active involvement of the member as part of the interdisciplinary team to be supported in making informed decisions about services and supports received. The comprehensive service plan identifies at all needs of the member and identifies services and supports that can be accessed to meet the needs. The service plan looks for all community supports, not just those available through the Habilitation program. The member is afforded choice in the services and supports available to meet their need.

In situations where the rules do not specifically identify the support of members to be in the center of the person centered planning process, the state will modify existing rules to better clarify the role of the member in directing and selecting services and the support they received to fully engage in the member in the person centered planning process.

For the Intellectual Disability Waiver, service planning based on individual needs and desires is addressed in 441—IAC—83.61(2)“g” and 441—IAC—83.67(1) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: these rules state:

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent SIS (Supports Intensity Scale) assessment or of the SIS contractor’s off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer’s family, case manager or service worker, service providers, and others directly involved.

The member is considered an active member on the IDT. The services and supports received are based on the member’s wants, needs and desires.

For the Brain Injury Waiver, service planning based on individual needs and desires is addressed in 441—IAC—83.82(2)“a” and 441—IAC—83.87 .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: the rule states:

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services using the following criteria

The member is considered an active member on the IDT. The services and supports received are based on the member’s wants needs and desires.

For Health and Disability Waiver interim medical monitoring and treatment (IMMT) services, 441—IAC—78.34(8)“d”(4) limits the settings in which the service may be provided.	Possible conflict	Rule will be amended to remove settings restrictions.	See section 2.3.5
<u>Summary:</u> This rule allows IMMT services to be provided in residential care facilities (RCF) or adult day care settings as well as other community integrated settings. These two setting will require the approval of a heightened scrutiny review prior allowing service.			
For Intellectual Disability Waiver interim medical monitoring and treatment (IMMT) services, 441—IAC—78.41(9)“d”(4) limits the settings in which the service may be provided.	Possible conflict	Rule will be amended to remove settings restrictions.	See section 2.3.5
<u>Summary:</u> This rule allows IMMT services to be provided in residential care facilities (RCF) or adult day care settings as well as other community integrated settings. These two setting will require the approval of a heightened scrutiny review prior allowing service.			
For Brain Injury Waiver interim medical monitoring and treatment (IMMT) services, 441—IAC—78.43(14)“d”(4) limits the settings in which the service may be provided.	Possible conflict	Rule will be amended to remove settings restrictions.	See section 2.3.5
<u>Summary:</u> This rule allows IMMT services to be provided in residential care facilities (RCF) or adult day care settings as well as other community integrated settings. These two setting will require the approval of a heightened scrutiny review prior allowing service.			
Federal Requirement: Settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.			
State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, restraints and restrictions are addressed in 441—IAC—77.25(4) and 441—IAC—78.27(4)“c” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<u>Summary:</u> 77.25(4) Restraint, restriction, and behavioral intervention. The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections			
For all HCBS members receiving Targeted Case management or Community-Based Case Management through an MCO, freedom from restrictions is addressed in 441—IAC—90.5(4) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

<p><u>Summary:</u> This rule identifies: 90.5(4) Rights restrictions. Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes: a. Documentation of why there is a need for the restriction; b. A plan to restore those rights or a reason why restoration is not necessary or appropriate; and c. Documentation that periodic evaluations of the restriction are conducted to determine continued need.</p>			
For Health and Disability Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.34(14)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> 78.34(14)b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For Elderly Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.37(19)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> This rule identifies the general service standards for the EW. The rules state: 78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards: b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For AIDS/HIV Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.38(10)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> 78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards: b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For Intellectual Disability Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.41(16)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

<p><u>Summary:</u> 78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:</p> <p>b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For the Brain Injury Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.43(16)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> 78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:</p> <p>b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For the Physical Disability Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.46(7)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> 78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:</p> <p>b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan</p>			
For the Children's Mental Health Waiver, requirements for services to be provided in the least restrictive environment are addressed in 441—IAC—78.52(1)"b" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> 78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:</p> <p>b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.</p>			
For the Elderly Waiver, restrictions of rights are addressed in 441—IAC—83.22(2)"d" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

- (1) Observable or measurable individual goals.
- (2) Interventions and supports needed to meet those goals.
- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
- (5) The desired individual outcomes.
- (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
- (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

For the Intellectual Disability Waiver, restrictions of rights are addressed in 441—IAC—83.67(4)"c" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: 83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.

For the Brain Injury Waiver, restrictions of rights are addressed in 441—IAC—83.87(1)"c" .			
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Summary: 83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer’s living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer’s rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.

Federal Requirement: Settings optimize, but do 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.

State Rule	Determination	Action Needed	Timeline
For Health and Disability Waiver respite services, individual preferences are addressed in 441—IAC—77.30(5)"b" , and use of settings used by the general public is addressed in 441—IAC—77.30(5)"d" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:

- 1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
- 2. An emergency medical care release.
- 3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.
- 4. The consumer’s medical issues, including allergies.
- 5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns

d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

<p>For Elderly Waiver respite services, individual preferences are addressed in 441—IAC—77.33(6)"b", and use of settings used by the general public is addressed in 441—IAC—77.33(6)"d".</p>	<p>The majority of rules supports.</p>	<p>Additional rule language needed to clarify CMS setting regulations</p>	<p>See section 2.3.5</p>
<p>Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:</p> <ol style="list-style-type: none"> 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver. 2. An emergency medical care release. 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver. 4. The consumer's medical issues, including allergies. 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns <p>d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.</p>			
<p>For AIDS/HIV Waiver respite services, individual preferences are addressed in 441—IAC—77.34(5)"b", and use of settings used by the general public is addressed in 441—IAC—77.34(5)"d".</p>	<p>The majority of rules supports.</p>	<p>Additional rule language needed to clarify CMS setting regulations</p>	<p>See section 2.3.5</p>
<p>Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:</p> <ol style="list-style-type: none"> 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver. 2. An emergency medical care release. 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver. 4. The consumer's medical issues, including allergies. 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns <p>d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.</p>			
<p>For Intellectual Disability Waiver respite services, individual preferences are addressed in 441—IAC—77.37(15)"b", and use of settings used by the general public is addressed in 441—IAC—77.37(15)"d".</p>	<p>The majority of rules supports.</p>	<p>Additional rule language needed to clarify CMS setting regulations</p>	<p>See section 2.3.5</p>

Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

For Brain Injury Waiver respite services, individual preferences are addressed in [441—IAC—77.39\(14\)"b"](#), and use of settings used by the general public is addressed in [441—IAC—77.39\(14\)"d"](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

For Children's Mental Health Waiver respite services, individual preferences are addressed in [441—IAC—77.46\(5\)"c"](#), and use of settings used by the general public is addressed in [441—IAC—77.46\(5\)"f"](#).

The majority of rules supports.

Additional rule language needed to clarify CMS setting regulations

See section 2.3.5

Summary: b. Respite providers shall meet the following conditions: (1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.
4. The consumer’s medical issues, including allergies.
5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns

d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

For Health and Disability Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.34(13) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS HD waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
For Elderly Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.37(16) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS EW waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
For AIDS/HIV Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.38(9) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS AIDS/HIV waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
For Intellectual Disability Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.41(15) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS ID waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
For Brain Injury Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.43(15) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS BI waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
For Physical Disability Waiver consumer choices option services, individual choice, autonomy, and opportunities for community living and inclusion are addressed in 441—IAC—78.46(6) .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
The Consumer Choices Option (CCO) is the state’s self-direction program available to members that access HCBS PD waiver services. As a self-direction program, the member has both budget and employer authority giving them total control over hiring and firing staff, scheduling needed supports and services, setting employee wages and approving payment for services.			
Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.			
State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, individual choice in services and providers is addressed in 441—IAC—78.27(4)”a” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Rules support that the member’s service plan provides individualized, planned, and appropriate services that are developed with the member in collaboration with an interdisciplinary team, as appropriate			
For Health and Disability Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.34(7)”a” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

For Elderly Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.37(15)"a" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

For AIDS/HIV Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.38(8)"a" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

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(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

For Intellectual Disability Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.41(8)"a" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

For Brain Injury Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.43(13)"a" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

For Physical Disability Waiver consumer directed attendant care (CDAC) services, individual choice in services and providers is addressed in 441—IAC—78.46(1)"a" .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: This rule identifies that the member is responsible for selecting a provider and identifying service components that will be provided to meet their individual needs. with regards to service planning:

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable..

For Intellectual Disability Waiver supported employment, respite, and supported community living services, choice in services and providers is addressed in 441—IAC—77.37(2)“h” and “s” . For ID Waiver residential-based SCL for children, these are addressed in 441—IAC—77.37(23)“d” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Individual outcomes in this rule support member choice and input in where they work and the services they receive See outcome based standards for rights and dignity rules referenced above			
For Brain Injury Waiver supported employment, behavioral programming, and supported community living services, choice in services and providers is addressed in 441—IAC—77.39(2)“h” and “s” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Individual outcomes in this rule support member choice and input in where they work and the services they receive See outcome based standards for rights and dignity rules referenced above			
For the Children’s Mental Health Waiver, this is addressed in 441—IAC—77.46(1)“c” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Individual outcomes in this rule support member choice and input in the services they receive. See individual outcomes, above			
For the Elderly Waiver, choice and participation in service planning are addressed in 441—IAC—83.22(2)“d” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Rules identify the person centered service planning process requirements for the elderly Waive program. See above			
For all HCBS members receiving Targeted Case management or Community-Based Case Management through an MCO, active participation of the member in service planning including choice of providers, is addressed in 441—IAC—90.5(1)“b” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: Rules identify the person centered service planning process requirements for the targeted case manager and community based case manager. See 90.5(1)b. service plan rules above			
Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.			
State Rule	Determination	Action Needed	Timeline

<p>For the Intellectual Disability Waiver, 441—IAC—77.37(3) requires a contract for residential services, but does not specify that it must have protections equal to landlord tenant laws.</p> <p>Residential services are also provided through the Brain Injury Waiver and the Habilitation Services program, which do not have a requirement of this type.</p>	Possible conflict	Rules will be amended to clarify.	See section 2.3.5
<p>The ID waiver contracts with members states: 77.37(3) Contracts with consumers. The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider. a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment. b. Contracts shall be reviewed at least annually. The BI and Habilitation programs also provide residential services that may be provided in a provider owned or controlled setting. Rules will be promulgated to mirror the ID waiver provider contract requirements.</p>			
<p>Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.</p>			
<p>State Rule</p>	<p>Determination</p>	<p>Action Needed</p>	<p>Timeline</p>
<p>For Intellectual Disability Waiver supported employment, respite, and supported community living services, this is addressed in 441—IAC—77.37(2)"e" and "r".</p>	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> Individual outcomes in this rule support member choice and input in areas of personal privacy and intimacy in their lives. See outcome based standards for rights and dignity rules referenced above</p>			
<p>For Brain Injury Waiver supported employment, behavioral programming, and supported community living services, this is addressed in 441—IAC—77.39(2)"e" and "r".</p>	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
<p><u>Summary:</u> Individual outcomes in this rule support member choice and input in areas of personal privacy and intimacy in their lives.</p>			
<p>Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p>			
<p>State Rule</p>	<p>Determination</p>	<p>Action Needed</p>	<p>Timeline</p>
No applicable rule found.	Silent	Rules will be amended to add this requirement.	See section 2.3.5

Summary: Rules currently do not address lockable doors in a member’s living unit. Rules will be promulgated to address the lockability of living units doors, both exterior doors and to individual sleeping unit,			
Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.			
State Rule	Determination	Action Needed	Timeline
For Intellectual Disability Waiver supported employment, respite, and supported community living services, this is addressed in 441—IAC—77.37(2)“j” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: The Individual outcome in this rule supports a member’s choice in where and with whom they live. See outcome based standards for rights and dignity rules referenced above			
For Brain Injury Waiver supported employment, behavioral programming, and supported community living services, this is addressed in 441—IAC—77.39(2)“j” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
Summary: The Individual outcome in this rule supports a member’s choice in where and with whom they live. See outcome based standards for rights and dignity rules referenced above			
Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.			
State Rule	Determination	Action Needed	Timeline
For any HCBS service provided in a residential care facility, 441—IAC—54.4(4) states that a facility “may” allow residents to provide their own furnishings.	Possibly Conflicts	Rule will be amended to explicitly allow residents to furnish and decorate their units.	See section 2.3.5
Summary: Facility rules state that “it is the responsibility of the facility to completely furnish the member’s room without additional charge. When the member wishes to provide some item or items of room furnishing, the facility may grant the request”. This rule does not directly limit a member’s freedom to furnish and decorate their sleeping or living units. Providers of facility services have the ability to establish policies and procedures and work with a member to give them choice how their sleeping and living space is decorated.			
Federal Requirement: In provider-owned or controlled residential settings individuals have the freedom and support to control their schedules and activities and have access to food any time.			
State Rule	Determination	Action Needed	Timeline
For Intellectual Disability Waiver supported employment, respite, and supported community living services, this is addressed in 441—IAC—77.37(2)“i” and “k” . For ID Waiver residential-based SCL for children, these are addressed in 441—IAC—77.37(23)“b” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5

Summary: Individual outcomes in this rule support member choice and input in how they spend their free time and choosing their daily routine. See outcome based standards for rights and dignity rules referenced above

For Brain Injury Waiver supported employment, behavioral programming, and supported community living services, this is addressed in 441—IAC—77.39(2)“i” and “k” .	The majority of rules supports.	Additional rule language needed to clarify CMS setting regulations	See section 2.3.5
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Summary: Individual outcomes in this rule support member choice and input in areas of personal privacy and intimacy in their lives. See outcome based standards for rights and dignity rules referenced above

Federal Requirement: In provider-owned or controlled residential settings individuals may have visitors of their choosing at any time.

State Rule	Determination	Action Needed	Timeline
No applicable rule found.	Silent	Rules will be amended to add this requirement.	See section 2.3.5

Summary: The IAC rules do not specifically address the time of day when visitors are allowed in provider owned or controlled environments. Since the rules are silent, it is up to the each provider to develop policy and procedures around visiting times within the member’s home.

Federal Requirement: In provider-owned or controlled residential settings the setting is physically accessible to the individual.

State Rule	Determination	Action Needed	Timeline
No applicable rule found.	Silent	Rules will be amended to add this requirement.	See section 2.3.5

Summary: The rules applicable for provider owned or controlled settings do not specifically address the need for accessibility. Member do have choice in where the live and with whom they live. Members have the ability to move to different locations that better meet their needs if they choose.

Overall conclusions: The state’s systematic assessment of the Iowa Administrative Code (IAC) rules included a review and analysis of all applicable rules for service delivery, provider qualifications, and locations and settings where HCBS services are provided. The state’s analysis found the majority of the IAC rules support a member’s full access and inclusion in community settings, choice in where they live and the supports they receive, and their right to live, work and recreate within the communities they choose.

The analysis of the rules was conducted by the state’s subject matter experts (SME) in HCBS waiver and Habilitation program services. The SMEs not only used their expertise in understanding the policy as written into the Iowa Administrative Code rules, but also their knowledge and historical involvement with the development and implementation of HCBS waiver and Habilitation services. This knowledge and expertise includes:

- Training and technical assistance provided to HCBS and Habilitation service providers and case managers around community integration, person centered planning and individual value based outcomes.
- Training provided to case managers through statewide, regional, and individual provider training and technical assistance that address the implementation of HCBS and Habilitation services.
- Consultation and statewide training provided by Michael Smull on Essential Lifestyle Planning and Derrick Dufresne on Five-Star Quality
- Ongoing HCBS and Habilitation quality assurance activities and subsequent corrective actions required to come into compliance with IAC rules
- Case Management quality assurance oversight.
- Program integrity activity findings.
- Development and implementation of new services like consumer directed attendant care (CDAC) and Self-direction Services (CCO)

Iowa has a long history of providing supports and services to HCBS and Habilitation members that allows members to choose where and with whom they live. Prior to July 1, 1992 when the ID waive began, HCBS services were only 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 BI Waiver) provision of 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 agreements were established and were 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 promulgated in the IAC rules reflect the department's intent that HCBS and Habilitation services are provided to members in integrated community based settings and allow the member to choose supports and services to remain living in their home and community. As identified in the analysis conducted in section 2.3.1, the state believes that the majority of the rules currently in the IAC support the CMS settings regulations as identified above.

With this in mind, the rules analysis identified possible conflicts with the new federal settings regulations. The identified conflicts will require rules changes to address the conflict to come into compliance. For example, IAC chapter 78 rules that define waiver services allows Interim Medical Monitoring and Treatment (IMMT) services to be provided in residential care facilities or adult day care settings as well as other community integrated settings. IMMT services that are provided in these two setting will require heightened scrutiny review and approval prior allowing service provision in those settings. Rules will be promulgated to reflect the need for site approval.

The rules analysis also identified the need for additional rule development regarding landlord tenant agreements in provider owned or controlled residential environments. The ID waiver is the only waiver that requires that a provider establish a contract with a member. The contract defines the responsibilities of the provider and the member, the rights of the member, the services to be

provided to the member by the provider, and all room, board, and copay fees to be charged to the member and the sources of payment. The contract is separate from any lease or rental agreement that may be in place. The IAC rules do not address the need for a lease agreement between a member and the provider when the provider owns or has a vested interest in the property where the member resides. The state has identified the need to add the contract language that is currently required in the ID waiver to be included in the BI waiver. The state will also promulgate rules applicable to provider owned or controlled settings to require lease agreements with members. The lease shall meet all landlord tenant laws of state, county, city or other designated entity in Iowa. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement will be required providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

The rules analysis identified additional conflicts when services are provided in provider owned and controlled environments that will require additional rule changes or modification. The first issue is lockable doors. The IAC rules for HCBS services are silent on members having lockable doors to living and sleeping units. As such, rules will be promulgated to assure that members have the ability to lock entrance doors to their home or to their individual sleeping units with appropriate staff having access to keys to the locks as needed to assure member health and safety.

The second issue in provider owned or a controlled setting is the ability to have visitors of their choosing at any time. The current IAC rules do not limit or prevent a member from having visitors at any time of the day. As such, the ability to limit visiting times may be determined by individual provider policies and procedures or the individual decisions of provider staff working within the home. Rules will be promulgated 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 will be promulgated 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 CH 77 rules for the PD Waiver and the CH 79 rules were assessed as being silent on the HCBS settings. The Ch. 77 rules are addressed and summarized above. CH 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 CH 79 rules are needed.

As identified in the analysis of the IAC rules in section 2.3.1 above, the state believes that the majority of the HCBS waiver and Habilitation program rules support the CMS settings and person centered planning requirements. The state recognizes that many of Iowa's current HCBS and Habilitation program rules have been developed over many years and may not directly or comprehensively support the language of the new CMS settings and person centered planning regulations. In order to support the CMS settings regulation, Iowa has drafted initial rule changes to provide direction to all HCBS services and service providers within the state. The initial rules were drafted to address the CMS settings and are currently being reviewed by the Iowa Attorney General's office. Through additional CMS review and feedback of Iowa's recently submitted drafts of the statewide transition plan, the state has identified a need for additional rule changes that were not included with the initial draft of the HCBS rules. In addition to the above service specific rules changes, the state will make the following rule changes to each chapter applicable to the HCBS waivers and the Habilitation program in the Iowa Administrative Code to fully comport with CMS regulations. By making these changes, all rules for HCBS services and service providers will fully comport with the HCBS settings and person centered planning regulations. The following rule changes will be made:

1. Provider qualifications rules in IAC 441- Ch. 77 will include criteria for services that are provided in provider owned and controlled settings

2. Service definition rules in IAC 441- CH 78 will include the HCBS final rules for setting requirements:

- The setting is integrated in and supports 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.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does 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.
- Facilitates individual choice regarding services and supports, and who provides them.
- The unit or dwelling 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 tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or 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 the jurisdiction's landlord/tenant law.
- Each individual has privacy in their sleeping or living unit.
- Units have entrance doors lockable by the individuals, with only appropriate staff having keys.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically accessible to the individual.

3. Modifications to provider-owned settings requirements:

- The requirements must be documented in the person-centered service plan in order to modify any of the criteria.

- The person-centered service plan be reviewed, and revised upon reassessment of function need, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include informed consent of the individual.

4. Home and community-based settings do not include the following:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

IAC 441- CH 90 will include criteria to assure person centered planning concepts of:

- The member directing services
- Supportive decision making
- Conflict of interest and problem solving
- Making informed choices, and
- Having full access to the community and the resources.

To address these additional changes, remediation activities and timelines for rule promulgation have been extended from previously submitted STP drafts. Section 2.3.5 of this transition plan identifies the updated timelines. Each of the HCBS and Habilitation rules in the Iowa Administrative Code will be updated to clearly identify and reflect the CMS regulations for integrated settings and person centered planning.

Licensed Residential Facilities

For licensed facilities in which HCBS may be provided, the following survey and certification agency rules were reviewed. These rules are not under the purview of the Iowa Medicaid program and as such IME cannot directly make changes to these rules. The IME will initiate contact and consult with the Iowa Department of Inspections and Appeals (DIA), the entity that is responsible policy and oversight of residential care facilities and other licensed settings. The IME will provide education and technical assistance to DIA with regards to the CMS settings regulations and how to address any licensing rules that that are in conflict with CMS HCBS settings. The results shown here indicate whether the DIA rule supported the federal regulations, conflicted with the federal regulations, or was silent in respect to the regulations.

Survey and Certification Administrative Rules Summary of Results	
Rule	Result
481—IAC—57 : Residential Care Facilities	<p>Supports: rights to privacy, resident choice in service planning, choice in daily activities.</p> <p>Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.</p>
481—IAC—62 : Residential Care Facilities for Persons with Mental Illness	<p>Supports: service plan based on individual needs and preferences, services in least restrictive environment.</p> <p>Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.</p>
481—IAC—63 : Residential Care Facilities for the Intellectually Disabled	<p>Supports: service plan based on individual needs and preferences, services in least restrictive environment.</p> <p>Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.</p>
481—IAC—69 : Assisted Living Programs	<p>Supports: Occupancy agreement must conform to landlord tenant law, service plan based on individual needs and preferences, managed risk policies uphold autonomy, lockable doors on each unit.</p>
481—IAC—70 : Adult Day Services	<p>Supports: Service planning process is individualized to the</p>

	<p>assessed needs the member. Activities are planned based on the needs identified in a member's service plan and members are afforded choice in participation of program activities.</p> <p>Possible conflicts: ADC rules are either non-specific or silent on access to food, and use of community resources in service programming.</p>
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Overall Conclusions: The IME does not have authority over the rules that oversee and govern licensed facilities in Iowa. That responsibility is with the Department of Inspections and Appeals. As such, the IME does not have the authority to promulgate rules for settings that require licensure. The IME will initiate and work with DIA through the provision of education and technical assistance regarding the need for rule change to meet the CMS settings criteria in licensed facilities. The HCBS Quality Oversight Unit will also work with DIA licensed providers, through the use of the HCBS provider self-assessment process and the heightened scrutiny review of the settings, to assure that members receive services in appropriate settings. Timeline for working with DIA is included in section 2.3.5 of the STP

2.3.1.2 Policy Manuals

The HCBS provider manuals are maintained and updated by the Iowa Medicaid Enterprise. Provider manuals were updated in August 2014 to include the CMS residential setting criteria. Day Habilitation and prevocational services were updated to include the need for service provision in integrated community settings.

Provider manuals reflect the current rules that have been adopted and included in the Iowa Administrative Code. Updates occur when a change in the IAC rules have been promulgated. The rule change process in Iowa requires that proposed rules go through rigorous six month review prior to being published in the IAC. After being written by the department's subject matter expert, the proposed rules are reviewed and approved by the Attorney General's office, Fiscal Management, the IME Bureau Chief and the Medicaid Director. Once the initial approval has occurred the rules are made available for public comment. The when the rules are being formally adopted for publication in the IAC, The rules are reviewed and approved by an administrative rules committee. The administrative rules committee allows public comment on rules being adopted. Change to the final rules may occur during any of these review processes based on comments received. Due to the potential for change throughout the rules making process, Provider and Employee manuals are not updated until rules have been formally adopted.

The rules identified in section 2.3.1.1 Administrative Rules (above) have been reviewed to determine if the rules support or conflict with implementation of the HCBS setting requirements. When the rule changes to the Iowa Administrative Code have been identified as needed to support the HCBS settings, the Provider Manual will be updated upon final promulgation of the rule. The HCBS provider manual is available on the IME website at: <https://dhs.iowa.gov/sites/default/files/HCBS.pdf>.

2.3.1.3 Other Standards

The only other identified standard is the Provider Agreement which is signed by every provider upon enrollment with the Iowa Medicaid program. The provider agreement does not directly support or conflict with the settings regulations; however, it does indirectly support the regulation in that it requires providers to comply with all applicable state and federal laws and regulations. The provider agreement is available on the IME website at:

https://dhs.iowa.gov/sites/default/files/470-2965%20Iowa%20Medicaid%20Provider%20Agreement%20General%20Terms_1.pdf

2.3.2: Systemic Assessment: Settings Analysis

As an initial step in assessing compliance, Iowa examined the settings associated with the services available in each of the state's HCBS programs in order to guide the state's approach to further assessment activities.

Rationale for determinations:

✓	Settings where these services provided fully comply with the regulation because the services by their nature are individualized, provided in the community or the member's private home, and allow full access to the broader community according to individual needs and preferences. Individuals choose which services and supports they receive and who provides them. Providers of these services will not undergo the site-specific assessment process.
?	Certain settings where these services are provided may require changes to fully comply with the regulation. Providers of these services will undergo the assessment process, and when necessary the remediation or heightened scrutiny processes.
	Service is not applicable for the HCBS program.

Results are indicated in the following chart:

Services by Program	AIDS/HIV	Brain Injury	Children's Mental Health	Elderly	Health & Disability	Intellectual Disability	Physical Disability	1915(i) Habilitation
Adaptive Devices			✓					
Adult Day Care	?	?		?	?	?	?	
Assistive Devices				✓				
Assisted Living				✓				
Behavioral Programming		?						
Case Management		✓		✓				✓
Chore				✓				
Financial Management Services (for Consumer Choices Option)	✓	✓		✓	✓	✓	✓	

Consumer Directed Attendant Care (Individual Provider)	✓	✓		✓	✓	✓	✓	
Consumer Directed Attendant Care (Agency or Assisted Living Provider)	?	?		?	?	?	?	
Counseling	?				?			
Day Habilitation						?		?
Emergency Response		✓		✓	✓	✓	✓	
Environmental Modifications			✓					
Family and Community Support			?					
Family Counseling & Training		?						
Home-Based Habilitation								?
Home Delivered Meals	✓			✓	✓			
Home Health Aide	✓			✓	✓	✓		
Homemaker	✓			✓	✓			
Home and Vehicle Modifications		✓		✓	✓	✓	✓	
In-home Family Therapy			✓					
Interim Medical Monitoring & Treatment		✓			✓	✓		
Mental Health Outreach				?				
Nursing	✓			✓	✓	✓		
Nutritional Counseling				✓	✓			
Prevocational Services		?				?		?
Respite	?	?	?	?	?	?		
Respite (provided in an institution per 42 CFR 441.301(c)(4)-(5))	✓	✓	✓	✓	✓	✓		
Senior Companion				✓				
Supported Community Living		?				?		
Specialized Medical Equipment		✓					✓	
Residential-Based Supported Community Living (for children)						?		

Supported Employment		✓				✓		✓
Therapeutic Resources			✓					
Transportation		✓		✓		✓	✓	

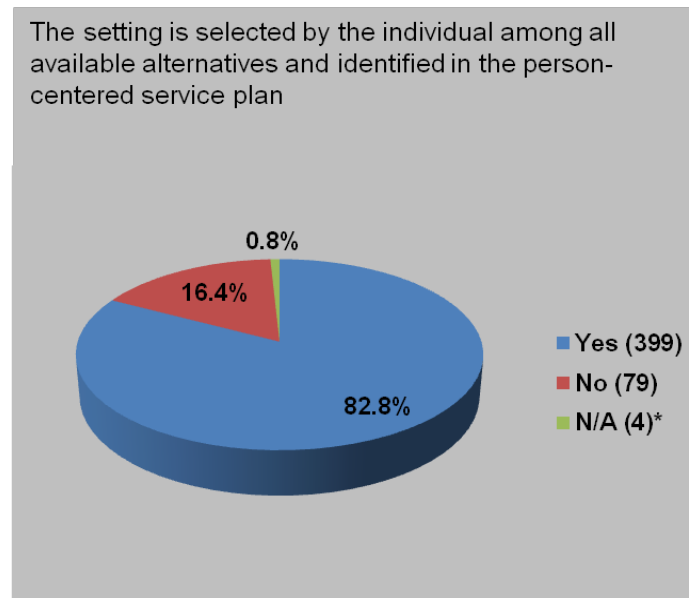
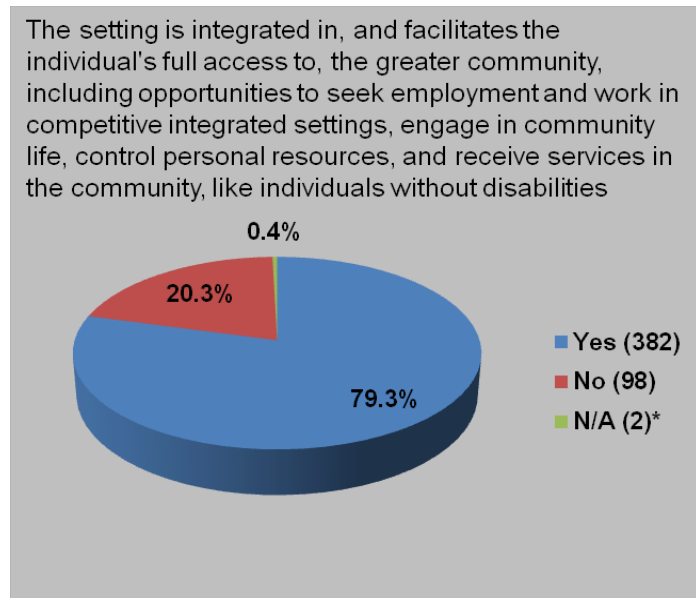
Regardless of classification in the above chart, any licensed facility in which an HCBS service is provided, will be evaluated using the method described in section 2.3.4.1 of this transition plan to determine whether the setting should be subject to the heightened scrutiny process.

2.3.3: Systemic Assessment: Preliminary Assessment Data

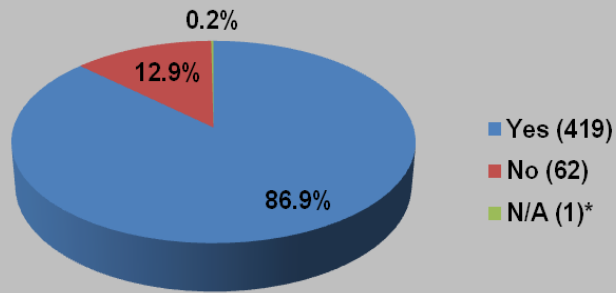
Iowa’s initial version of the statewide transition plan included a provider self-assessment process and an onsite review process. These activities have been refined as described below in section 2.3.4 “Site-Specific Assessment Process”; however Iowa has been able to use information gathered through these preliminary processes to help describe the baseline level of compliance at a systemic level.

2.3.3.1: Preliminary Provider Self-Assessment Results

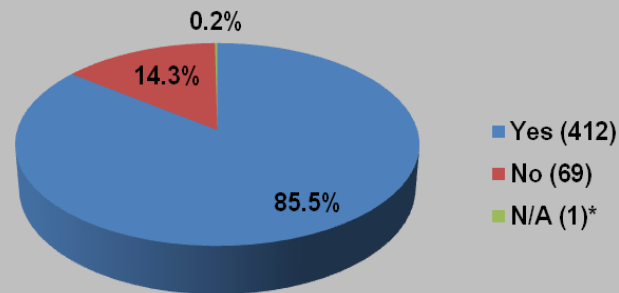
The following graphs present the results of the 2014 Provider Self-Assessment:



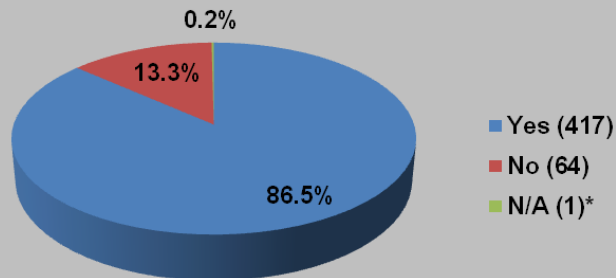
An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected



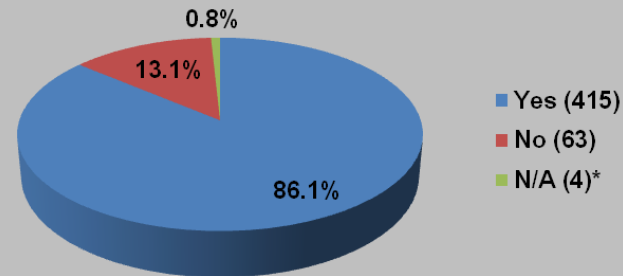
Individual initiative, autonomy, and independence in making major life choice, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and regimented



Individual choice regarding services and supports, and who provides them, is facilitated

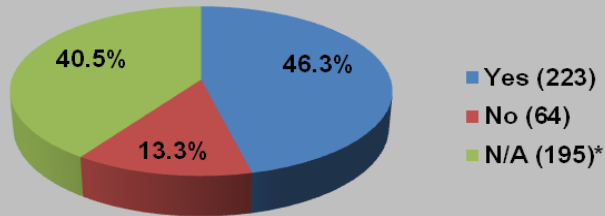


Any rights restriction (for example to address the safety needs of an individual with dementia) must be time limited, contain member's informed consent, supported by a specific assessed need and documented in the person-centered service plan

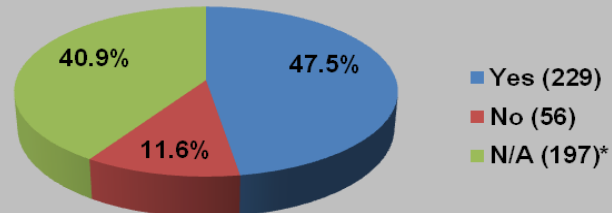


The following charts represent responses to questions that pertain only to provider owned or controlled settings. "Provider owned or controlled" was defined as: *a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS. This includes residential settings in which a provider of HCBS is present on a 24 hour per day basis, and includes settings where a separate legal entity has been established by a provider for ownership, leasing, or management of the property.* Providers of services that occur in settings that are not provider owned or controlled answered these questions as "not applicable" (N/A).

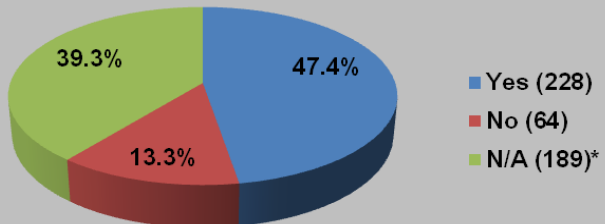
In a provider owned or provider controlled setting, each individual has privacy in their sleeping or living unit



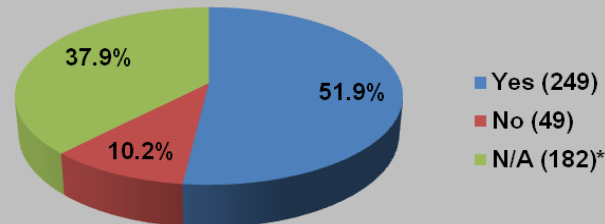
In a provider owned or provider controlled setting, individuals have the freedom and support to control their own schedules and activities, and have access to food at any time



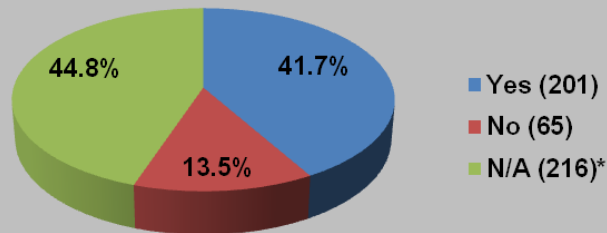
In a provider owned or provider controlled setting, individuals are able to have visitors of their choosing at any time



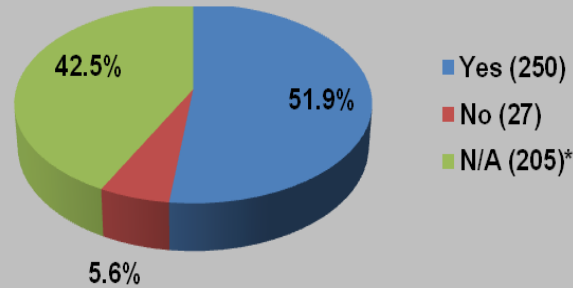
In a provider owned or provider controlled setting, the setting is physically accessible to the individual



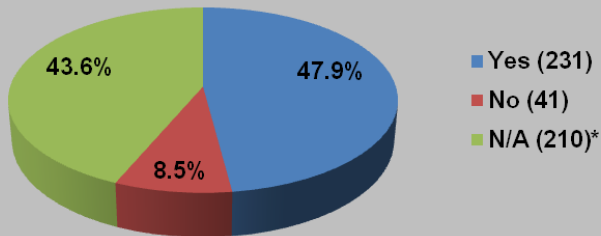
In a provider owned or provider controlled setting, individuals sharing units have a choice of roommates in that setting



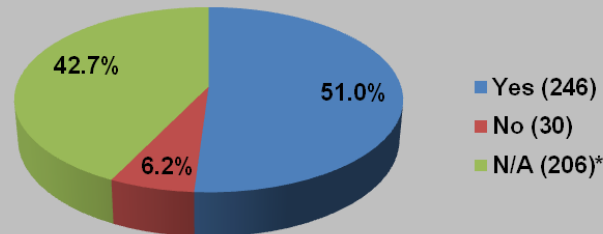
In a provider owned or provider controlled home individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement



Provider owned or provider controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity



Provider owned or provider controlled home has entrance doors lockable by the individual, with only appropriate staff having keys to doors



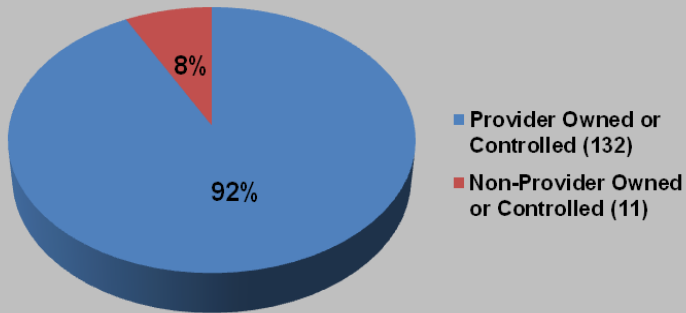
These preliminary provider self-assessment results indicate that the number of settings that are noncompliant with the regulation ranges from approximately 5% to 20% depending on the specific requirement. Results for the majority of questions (9 out of 14) indicate a noncompliance level of 10% to 15% of settings.

Any providers with a response of “no” on any of the above questions were instructed to submit a corrective action plan (CAP) to address the issue. Because CAPs submitted by providers often combined issues related to the settings regulation with other issues requiring a CAP, the state was unable to obtain data on the number of CAPs received specifically related to HCBS settings noncompliance. Iowa is revising its data tracking procedures in order to explicitly identify CAPs related to settings issues, and will collect this data as described in the remediation activities in Section 2.3.5 of this transition plan.

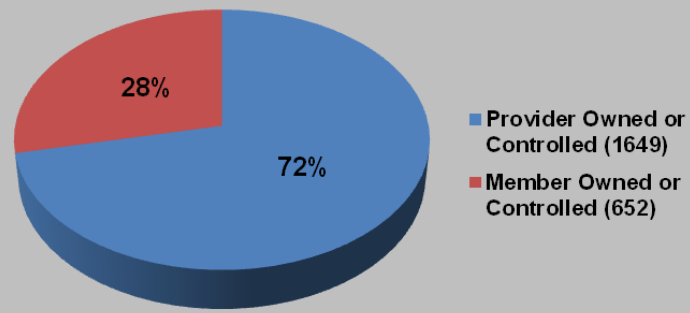
The 2014 Provider Self-Assessment asked providers to identify all specific settings in which HCBS was being provided. These locations were compiled and yielded the following information.

2,444 HCBS Sites Reported

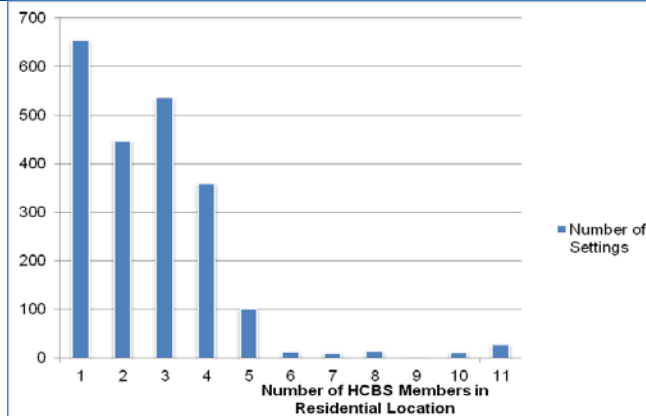
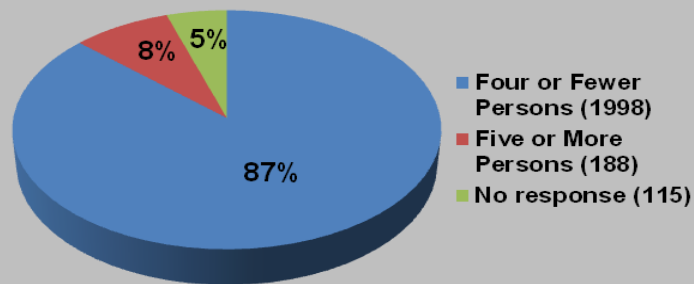
143 Non-Residential



2,301 Residential



Number of HCBS Members per Residential Location



Types of housing reported for members in settings that were member owned or controlled included houses, townhouses, condominiums, duplexes, and apartments.

Types of housing reported for members in provider owned or controlled settings included houses, townhouses, condominiums, duplexes, triplexes, apartments, senior housing, and RCF or assisted living.

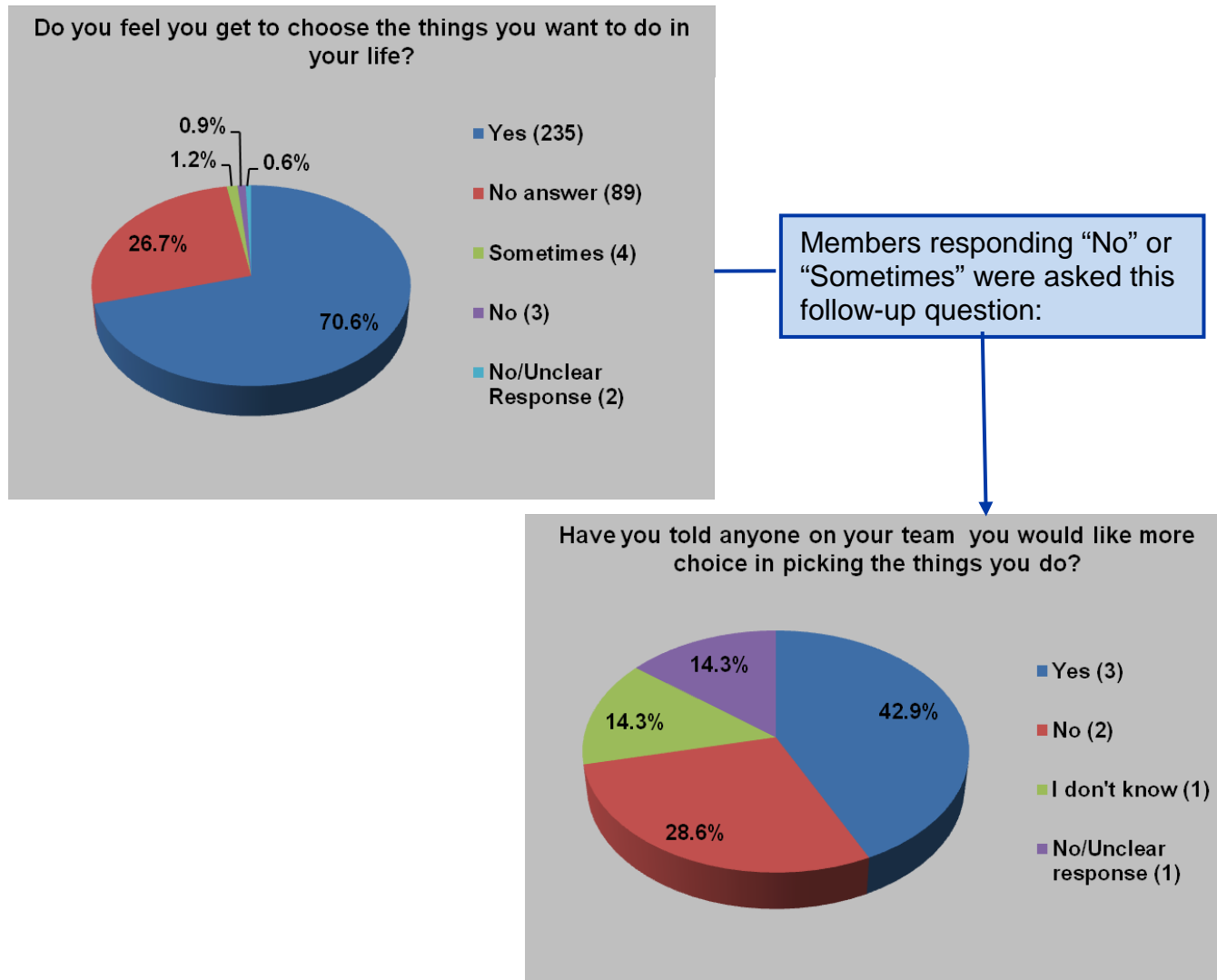
The complete listing of settings is provided in Appendix A of this transition plan. Street addresses and contact information has been removed to assure privacy of individuals receiving HCBS.

2.3.3.2 Preliminary Iowa Participant Experience Survey (IPES) results

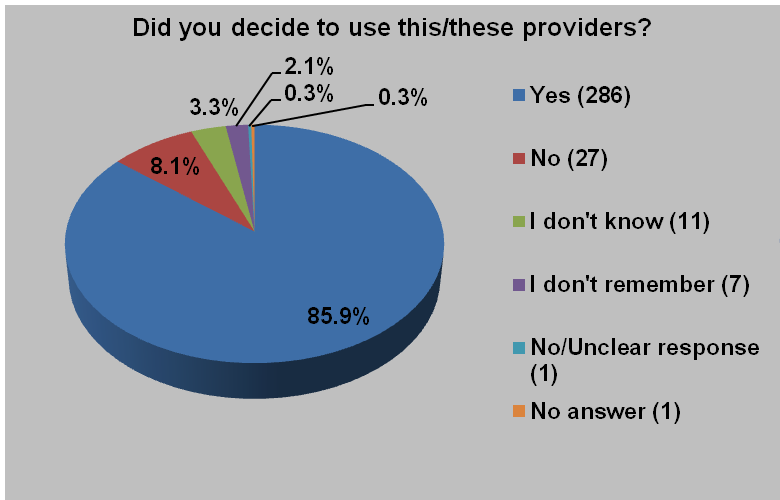
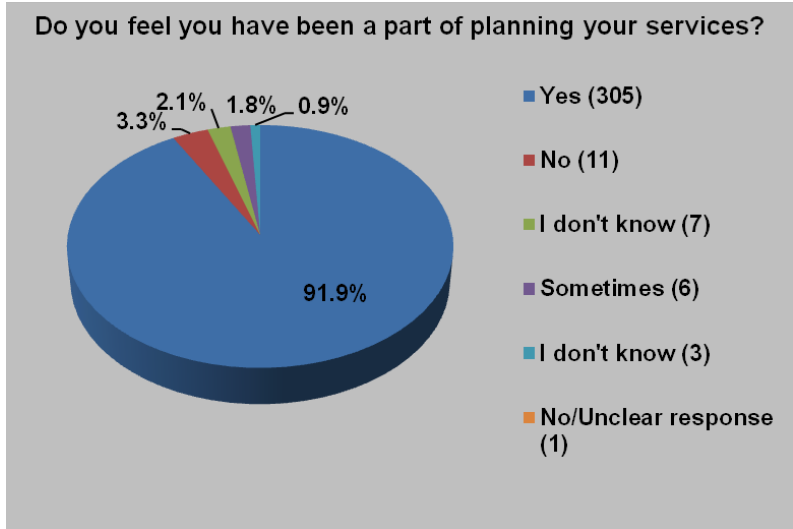
The IPES is a customized version of the Participant Experience Survey (PES) tools developed by CMS for use with HCBS programs. The IPES is conducted by HCBS Specialists from the HCBS Quality Assurance unit at the IME. Contact is made with the member's case manager prior to completion of the survey, and with the member at the time of scheduling, both of which provide opportunities to alert the HCBS Specialist of any assistance or accommodations that may be needed. The IPES interview is conducted in-person or by phone at the place and time of the member's choosing. If the member is unable to participate, a family member can be designated to respond on behalf of the member, however member participation is strongly encouraged. The HCBS Quality Oversight Unit selects the number of interviews each year with 95 % confidence level. During fiscal year '16, 333 members were interviewed using the IPES interview tool. The charts below represent baseline data from the IPES assessment to support for HCBS settings and person centered planning.

Iowa's initial version of the statewide transition plan included monitoring of the IPES survey results to flag any member experience that is not consistent with the HCBS settings regulations. This activity has been refined as described below in section 2.3.4 "Site-Specific Assessment Process"; however Iowa has been able to use information gathered through this preliminary process to help describe the baseline level of compliance at a systemic level. The following data is from IPES surveys conducted between July 1, 2014 and June 30, 2015.

The following results pertain to questions centering on individual initiative, autonomy, and independence in making life choices.

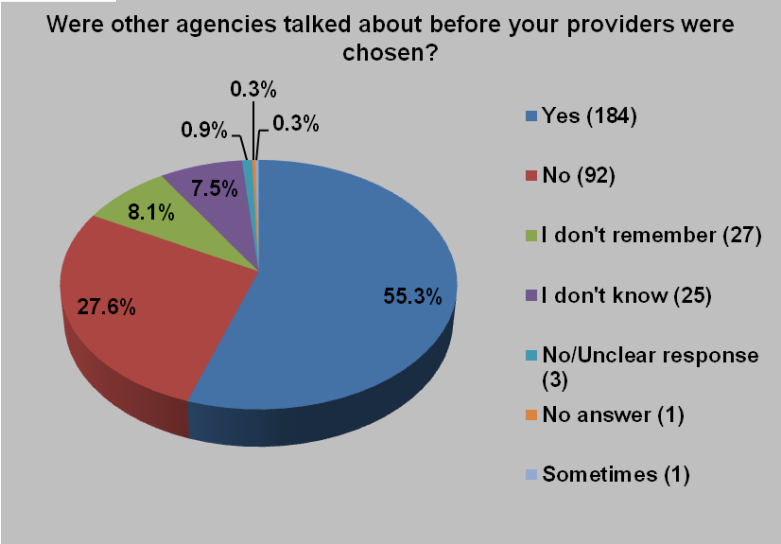
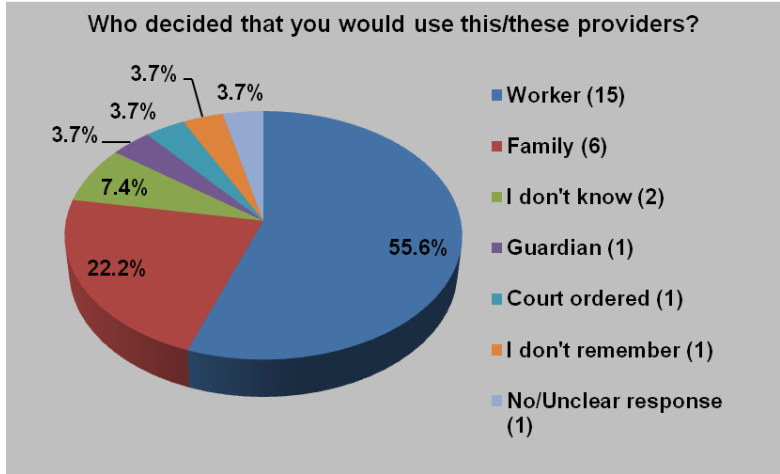


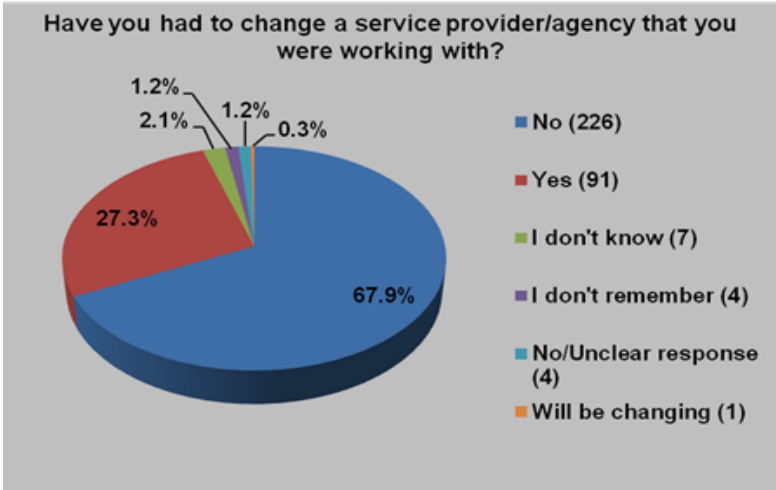
The following results pertain to questions centering on choice of services and providers.



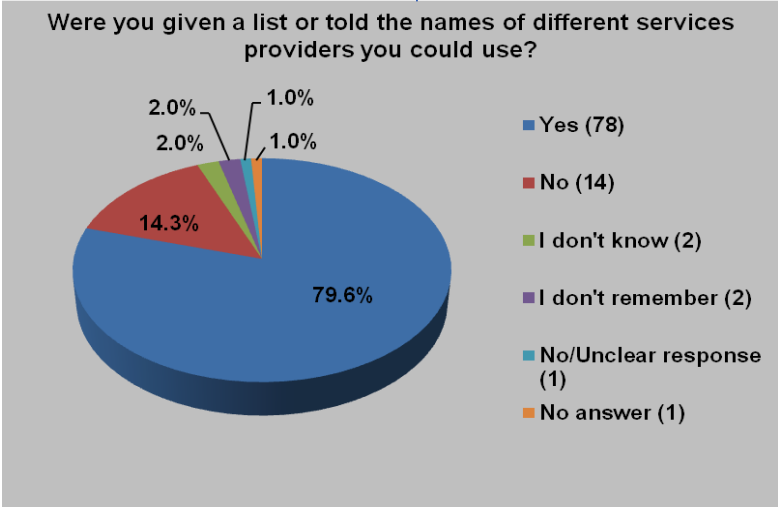
Members responding "No" were asked this follow-up question:



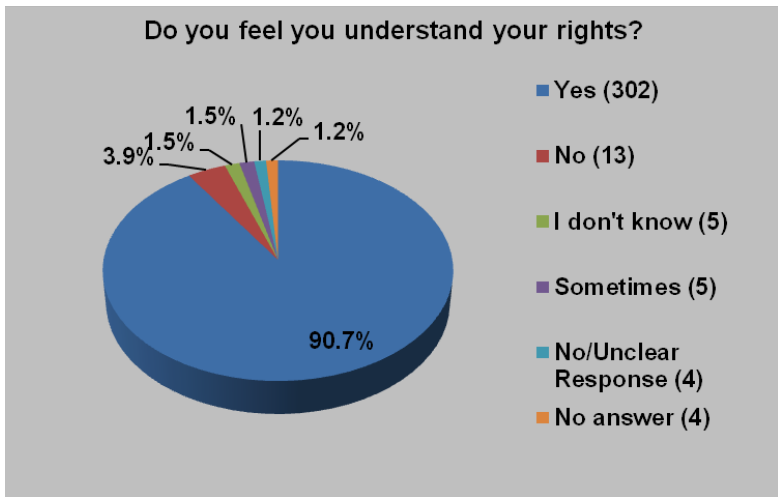




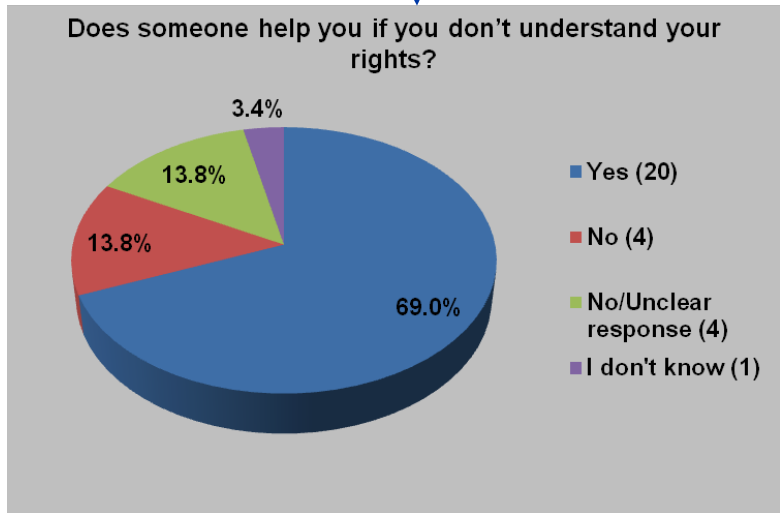
Members responding "Yes" or "I Don't Know" were asked this follow-up question:



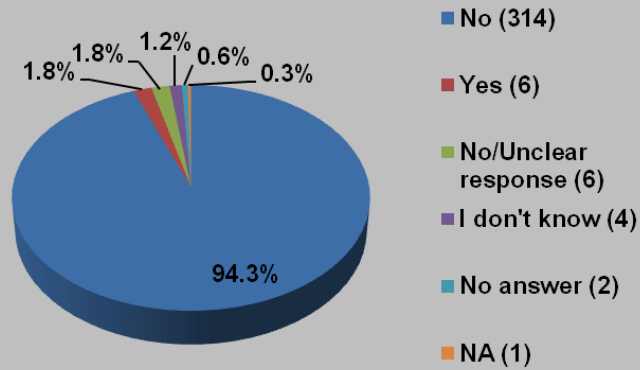
The following results pertain to questions centering on individual rights of privacy, dignity, respect, and freedom from coercion and restraint.



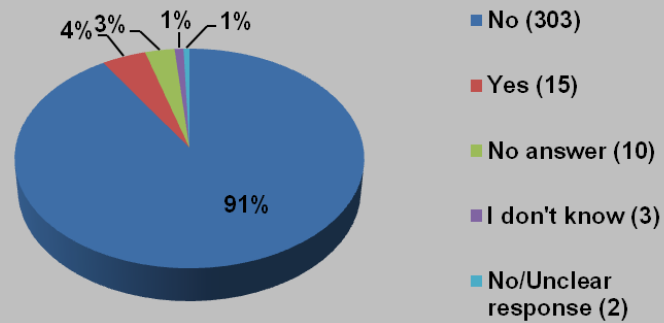
Members responding anything other than "Yes" were asked this follow-up question:



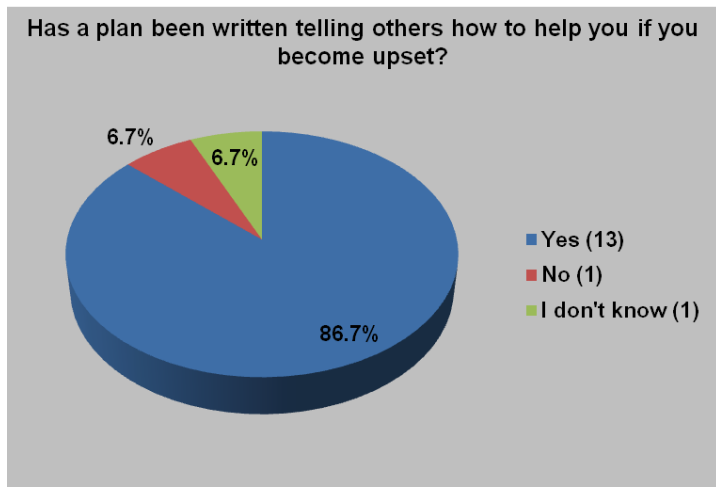
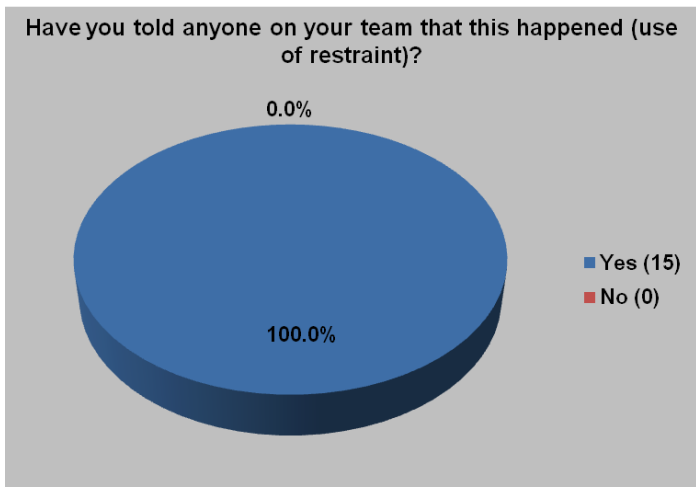
When a staff person is working with you, they should respect your rights. Staff can only limit rights if you agree to that. Has staff stopped you from doing something that you wanted to do?



There are different ways to calm a person down with restraint. Some of the ways include giving them medicine, a shot, being held down by another person, or being strapped down. Has this happened to you in the past 2 years?



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



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

These responses represent an aggregate baseline for Iowa. The state will continue to use IPES results on an individual member basis, combined with results from other assessment activities as described in Section 2.3.4 of this transition plan, to ensure compliance with the regulations.

2.3.4: Site-Specific Assessment Process

Iowa's original statewide transition plan submission included an assessment process that leveraged the state's existing HCBS quality assurance processes which utilize an ongoing cycle of discovery, remediation, and improvement. As such, the state did not plan to perform a one-time statewide assessment which would result in a point-in-time list of settings that were compliant or non-compliant. Iowa has already begun assessment activities using this approach.

However, guidance and feedback from CMS clearly indicates that there is an expectation for a point-in-time approach that should result in a classification of all settings into the categories of settings that are compliant; settings that may be compliant and with changes will comply; settings presumed to have institutional qualities but may be submitted for heightened scrutiny; and settings that do not comply.

As such, the statewide transition plan has been modified to take a hybrid approach to assessment. The information gained from assessment activities that have already begun will be used as a preliminary step in determining the state's baseline level of compliance, and to inform planning for ongoing activities. In this new approach, the provider self-assessment will still serve as a starting point, but new assessment activities have been added to the plan, in which additional assessments will be completed by the state's HCBS Quality Assurance Unit and by community-based case managers working through the state-contracted MCOs. These new activities will be completed by December 31, 2016, and will give the state a final baseline from which to work on remediation activities. Additionally, settings compliance will remain as a part of our ongoing quality assurance processes up to and beyond the March 17, 2019 transition deadline, to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis, as the state currently does for other state and federal requirements.

Assessment activities are outlined as follows:

ID	Activity	Description	Start Date	End Date
1	Issue Guidance for Providers	The State released the "Iowa Exploratory Questions for Assessment of HCBS Settings" document to assist providers in identifying the expected characteristics of HCBS.	10/1/2014	10/14/2014
2	2014 Provider Self-Assessment	<p>The state modified the existing Provider Quality Management Self-Assessment to:</p> <ol style="list-style-type: none">1) Identify HCBS sites2) Gather preliminary information from providers regarding compliance with settings regulations. <p>The 2014 self-assessment was released to providers on 10/1/2014 and was due back to the state on 12/1/2014. The state considers this a preliminary assessment activity to assist the state in determining a baseline level of compliance.</p>	10/1/2014	6/30/2015

		<p>Compilation of results was completed in June 2015, and is presented in Section 2.3.3 of this transition plan.</p> <p>Validation of results was done via a qualitative follow-up (described in activity #3) and by on-site assessments (described in activities #8, #9, and #12 below).</p>		
3	Provider Self-Assessment Qualitative Validation	A survey was sent to 96 randomly chosen HCBS providers to follow up on responses provided on the 2014 Self-Assessment. Responses were received from 57 providers. The survey asked providers to give additional qualitative information to demonstrate practices they have implemented to meet the settings regulations. Responses were analyzed to determine best practices.	5/1/2015	7/31/2015
4	Provider Stakeholder Group	<p>While the federal settings regulations are very specific about certain requirements for provider owned or controlled residential settings, the regulations are much less specific in regard to other settings. Additionally, guidance from CMS has not provided in-depth information about the outcome of integration for members.</p> <p>A representative group of providers was convened to participate in a collaborative effort to clarify expectations for community integration. Providers were chosen to include a variety of services which are provided in various settings, including licensed, non-licensed, residential, and non-residential settings. A series of three focus group meetings and one phone conference were held to provide the opportunity for providers to discuss how integration can be achieved and documented in each of these settings. From these meetings, the group developed four indicators of integrated settings and service delivery. Each indicator identifies examples of evidence that providers could gather to support the settings used in service delivery. See summary information below.</p>	9/1/2015	12/31/2015
5	Preliminary Onsite Assessment by HCBS Quality Oversight Unit	<p>The HCBS settings standards were incorporated into the review tools used by the HCBS Quality Oversight Unit for on-site reviews. During the onsite review, the HCBS Specialist validates the provider's responses from the self-assessment. Any standards that are found to be deficient require a corrective action plan (CAP) as detailed in section 2.3.5 of this transition plan.</p> <p>Certification reviews are done at enrollment for new providers and at one-year or three-year intervals for existing providers. For periodic reviews, every provider has an onsite review once during a five-year period. For focused reviews, a random selection of providers is taken such that all providers will be reviewed during a five-year cycle. Targeted reviews are done as the result of a complaint</p>	12/1/2014	6/30/2016

		made to the IME about a provider, so any time an HCBS Specialist is onsite for a complaint investigation, there may also be findings related to the settings regulation. Additionally, any time a plan of correction is required, the IME may choose to do a follow-up onsite review. With this review cycle, approximately 40% of HCBS providers will have an onsite review in any given year.		
6	2015 HCBS Provider Self-Assessment	<p>The Provider Quality Management Self-Assessment was revised to capture new HCBS sites that became operational after the 2014 self-assessment, and to identify sites that may require heightened scrutiny because the location is:</p> <ol style="list-style-type: none"> 1) In a publicly- or privately owned facility that provides inpatient treatment; or 2) On the grounds of, or immediately adjacent to, a public institution; or 3) Has the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. <p>The self-assessment was released to providers on 10/1/2015 and was due back to the state on 12/1/2015. Compilation of results is currently underway.</p> <p>Compliance will not be determined solely by self-assessment responses. Validation of results will be done through the onsite assessment processes (described in activities #8, #9, and #12 below).</p>	9/1/2015	6/30/2016
7	Onsite Assessment Training for MCO Community-Based Case Managers	Training for Community-Based Case Managers employed by the state's contracted MCOs will be provided to educate the case managers on the federal settings regulation, Iowa's statewide transition plan, and the specific tools and processes they will use in conducting the onsite assessments (described in activity #9 below).	10/1/2016	10/30/2016
8	Onsite Assessment of non-residential settings by HCBS Quality Oversight Unit	<p>Settings compliance is assessed during all periodic and certification reviews by the HCBS Quality Oversight Unit. In addition to the normal scheduled reviews, HCBS specialists will perform focused reviews of 100% of all non-residential HCBS providers.</p> <p>During the onsite focused review, the HCBS Specialist validates the provider's responses from the self-assessment. Any standards that are found to be deficient require a corrective action plan (CAP) as detailed in section 2.3.5 of this transition plan.</p>	10/1/2016	3/31/18

9	Onsite Assessment by MCO Community-Based Case Managers	<p>Community-based case managers serving members through Iowa's four <u>three</u> MCOs and the HCBS fee for service population will perform onsite reviews of residential HCBS members. Members will be randomly selected based on a statistically valid sample of members taken at the 95% confidence level.</p> <p>During the onsite review, the community-based case manager assesses compliance based on a checklist provided by the state. Any standards that are found to be deficient require a corrective action plan (CAP) as detailed in section 2.3.5 of this transition plan. Ongoing member residential assessments shall be conducted by the member's case manager as part of the annual service plan review process.</p>	11/1/2016	9/30/17
10	Submission of the final Statewide Transition Plan	<p>Based on the results of the onsite assessments, the state will classify all settings into the categories of settings that are compliant; settings that may be compliant and with changes will comply; settings presumed to have institutional qualities but may be submitted for heightened scrutiny; and settings that do not comply. The state will update the statewide transition plan to reflect the assessment results, to make any modifications that may be necessary based on the results, and to allow for additional public comments.</p>	7/1/2017	6/30/18
11	2016 and Ongoing Provider Self-Assessment	<p>The self-assessment will be released to providers annually on October 1 and will be due back to the state on December 1. If a provider does not submit the self-assessment, the HCBS Quality Assurance unit will make a follow-up contact to attempt to obtain the self-assessment. If the provider still does not comply, a referral will be made to the IME Program Integrity unit. The Program Integrity unit may sanction the provider as allowed under Iowa Administrative Code 441—79.2. Validation of results will be done through the ongoing onsite assessment processes (described in activity #12 below).</p>	10/1/2016	12/31/2018
12	Ongoing provider onsite assessments	<p>Assessment of compliance will remain as a part of the state's ongoing quality assurance process through the end of 2018, to assure that providers will continue to meet the requirements on an ongoing basis. Assessment for ongoing monitoring beyond 2018 is addressed below in Section 2.3.6 of this transition plan. During the onsite review, the HCBS Specialist validates the provider's responses from the most recent self-assessment. Any standards that are found to be deficient require a corrective action plan (CAP) as detailed in section 2.3.5 of this transition plan.</p> <p>Certification reviews are done at enrollment for new providers and at one-year or three-year intervals for existing providers. For periodic reviews, every provider has an onsite review once during a five-year period. For focused reviews, a</p>	1/1/2017	3/31/2018

		random selection of providers is taken such that all providers will be reviewed during a five-year cycle. Targeted reviews are done as the result of a complaint made to the IME about a provider, so any time an HCBS Specialist is onsite for a complaint investigation, there may also be findings related to the settings regulation. Additionally, any time a CAP is required, the IME may choose to do a follow-up onsite review. With this review cycle, approximately 40% of HCBS providers will have an onsite review in any given year.		
13	Iowa Participant Experience Survey (IPES)	The IPES is a customized version of the Participant Experience Survey (PES) tools developed by CMS for use with HCBS programs. The IPES is conducted by HCBS Specialists from the HCBS Quality Assurance unit at the IME. Contact is made with the member's case manager prior to completion of the survey, and with the member at the time of scheduling, both of which provide opportunities to alert the HCBS Specialist of any assistance or accommodations that may be needed. The IPES interview is conducted in-person or by phone at the place and time of the member's choosing. If the member is unable to participate, a family member can be designated to respond on behalf of the member, however member participation is strongly encouraged. The IPES files (MS Word documents) are available on the department website at: http://dhs.iowa.gov/sites/default/files/IPES%20Tools.zip . The state will continue to monitor IPES results to flag any member experience that is not consistent with assuring control over choices and community access. Any results flagged as such will require follow-up by the case manager.	12/1/2014	12/31/2018
14	Ongoing information, updates and announcements	Ongoing updates and information about the implementation of the Iowa statewide transition plan will be available on the department website at: http://dhs.iowa.gov/ime/about/initiatives/HCBS .	4/1/16	3/17/19
15	Ongoing stakeholder input from members, families, advocates, providers and other interested parties.	The department shall seek stakeholder input and feedback on the implementation of the statewide. At a minimum, the department shall provide opportunity for stakeholder input every six months through statewide webinars, focus groups or other means of input	7/1/16	12/31/18

As follow up to the HCBS Settings survey (ID # 3 above) sent to providers, a focus group of providers and HCBS Quality Assurance staff was gathered for three meetings and one conference call (ID #4). The intent of the focus group was to gather input from HCBS providers and HCBS Quality Oversight staff and to develop a set of indicators that identify what services would look like in HCBS

settings. The outcome of this focus group was the creation of four indicators for use by providers and quality oversight staff for development, provision, and oversight of HCBS services to assist providers to meet HCBS Settings requirements. Examples of evidence to support the implementation of the indicators were also developed. These draft indicators will receive additional stakeholder input from members and advocates prior to implementation.

Final Draft of Indicators:

- The majority of members receive most of their services in a setting that supports access to, and facilitates integration with the greater community within and outside the setting.
 - Evidence: Quality Assurance plan including QA activities to measure ongoing remediation and improvement on settings requirements, member/stakeholder experience interviews, member preference/needs assessment from service plan, daily service documentation
- Services provide choices and options to optimize autonomy in the member's daily routine.
 - Evidence: Member input in choice in time, location, type, and duration of services; service plan, IDT meeting minutes, member/stakeholder experience interviews, daily service documentation, staffing schedules
- Setting provides opportunities for meaningful and purposeful activities which facilitate personal growth and maintenance of skills, abilities, and desires.
 - Evidence: Member needs assessments, daily service documentation, service plan, member/stakeholder experience interviews, monthly or quarterly summary, IDT meeting minutes
- Members have the opportunity and support to access and manage personal resources.
 - Evidence: Member needs assessments, daily service documentation, service plan, member/stakeholder experience interviews, monthly or quarterly summary, IDT meeting minutes, receipts or spending ledgers, bills, leases, location of personal resources in member's home

2.3.4.1: Heightened Scrutiny

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

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

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

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

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

Unless CMS indicates otherwise, Iowa will operate under the assumption that correctional facilities are also excluded from this definition.

ID	Activity	Description	Start Date	End Date
1	Data Matching	<p>Iowa will utilize data matching 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 will use 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.</p> <p>To explore potential settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, the state will compare street addresses of HCBS sites to those of licensed hospitals, ICF/IDs, and nursing facilities/skilled nursing facilities. Because many assisted living sites provide HCBS, the state will also compare addresses of licensed assisted living sites of more than 5 beds with addresses of nursing facilities to determine if any are located in the same building.</p>	2/1/2016	6/30/2016

		<p>To explore potential settings that are located in a building on the grounds of or immediately adjacent to a public institution, the state will compare 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 appear to fall under the public institution definition noted above. Any addresses that are a close match but are not exact will be mapped to determine if they are adjacent.</p> <p>To explore other settings that may have the effect of isolating individuals receiving Medicaid HCBS from the broader community, the state will compare addresses for Residential Care Facilities (RCFs) of more than 5 beds with addresses for HCBS 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.</p> <p>Any other settings found through the assessment process described in section 2.3.4 of the transition plan to be potentially isolating, will also be subject to the heightened scrutiny process.</p>		
2	State Determinations	<p>Any location identified through data matching as potentially in conflict with the CMS settings regulations will be evaluated by the state to determine whether the setting has the qualities required for HCBS.</p> <p>The state will conduct onsite assessments at each identified location. These assessments will be performed by the HCBS Quality Oversight Unit or by MCO Community-Based Case Managers. The results of the onsite assessment will be reviewed by state HCBS policy staff who will determine whether or not the setting has the qualities of HCBS.</p>	7/1/2016	3/31/2018
3	Submission of Evidence for Heightened Scrutiny	<p>The state will update the statewide transition plan to reflect the state determinations, to make any modifications that may be necessary based on the results, and to allow for additional public comments.</p> <p>For any setting which the state determines has the qualities of HCBS, the state will submit to CMS all available evidence to demonstrate how the setting is compliant with the settings regulation. The state will submit the evidence periodically to CMS when individual provider reviews occur and a determination</p>	1/1/2017	6/30/2018

		is made that support the setting in meeting the HCBS setting criteria. For any setting which the state determines does not currently have the qualities of HCBS but is likely to be compliant with remediation, the state will require the provider(s) of services in that setting to submit a corrective action plan (CAP) as described below in remediation activity #3 in section 2.3.5 of this transition plan, and the state will submit to CMS all available evidence to demonstrate how the setting will become compliant with the settings regulation.		
4	Member Transitions to Compliant Settings	For any setting which the state determines does not have the qualities of HCBS and which is cannot be remediated, the state will ensure that members are transitioned to settings meeting HCBS settings requirements using the process described below in remediation activity #7 in section 2.3.5 of this transition plan.	1/1/2017	6/30/2018

2.3.5: Site-Specific Assessment Outcomes (Remediation)

Iowa’s remediation process capitalizes on existing HCBS quality assurance processes including identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements for providers to become compliant. Providers that fail to remediate noncompliant settings timely may be subject to sanctions by the department. Possible sanctions include:

- A term of probation for participation in the medical assistance program.
- Suspension of payments in whole or in part.
- Suspension from participation in the medical assistance program.
- Termination from participation in the medical assistance program.

Iowa Administrative Code 441-79.2(249A) identifies the grounds for sanctions and appeal rights of providers. A link to the IAC Sanction rules is: <https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf> (p. 62)

Remediation activities are outlined as follows:

ID	Activity	Description	Start Date	End Date
1	Initial Public and Provider Education and Resources	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: <ul style="list-style-type: none"> • A webpage dedicated to the topic was published on the IME website (http://dhs.iowa.gov/ime/about/initiatives/HCBS), which includes links to information from outside sources such as CMS, the National Senior 	4/1/2014	11/30/2014

		<p>Citizen’s Law Center, and HCBSAdvocacy.org</p> <ul style="list-style-type: none"> • A white paper was published to give an overview of the regulations and their impact on Iowa • Stakeholder forums were conducted in six locations across the state in May 2014, with additional forums by webinar in November 2014. Slides from these presentations are available on the website. • As guidance for providers, the state published an Iowa-specific version of the “exploratory questions for assessing settings” document and an Iowa-specific version of the “settings that isolate” document. 		
2	Rule Changes	<p>Through the rule review process conducted in section in section 2.3.1.1 Administrative Rules of this application, the state has identified rules changes required to come into compliance with the HCBS settings. Additional rules changes will be made based on comments received during the public comment period and feedback from CMS review of the statewide transition plan submitted for approval.</p> <p>The rule change process in Iowa requires a minimum of six months for final approval and publication in the Iowa Administrative Code. The process includes writing the new rule language, conducting a fiscal impact review, 30 day public comment period, approval by the IME Medicaid Director, Attorney General and Fiscal management unit, and final review by the Administrative Rules Committee.</p> <p>The state has previously identified many of the required rules changes that are needed to meet the HCBS Settings regulation. These rules have begun the rules change process and have been under review of the Attorney General’s office. Through additional CMS review and feedback of Iowa’s recently submitted drafts of the statewide transition plan, the state has identified a need for additional rule changes that were not included with the initial draft of the HCBS rules. The state will update all IAC rule chapters applicable to the HCBS Waiver and Habilitation programs. The specific rule language that will be used is identified in the overall conclusion summary at the end of section 2.3.1.1 beginning on page 44.</p> <p>By making these changes, all rules for HCBS services and service providers will fully comport with the HCBS settings and person centered planning regulations</p> <p>These additional rules will extend the previous projected timeline for final</p>	Rulemaking process began on April 1, 2016	September 30, 2017

		promulgation. Previous drafts of the statewide transition plan identified a January 1, 2017, date for rule changes to be completed. With the additional rules required for compliance, the final implementation date will be extended to September 30, 2017.		
3	Rule Change collaboration with DIA	The Department of Inspections and Appeals (DIA) has the regulatory oversight and rule writing authority for all licensed settings in the state of Iowa. The rules for licensed settings are not under the purview of the Iowa Medicaid program and as such IME cannot directly make changes to these rules. The IME will initiate contact and provide ongoing education and technical assistance to DIA with regards to the CMS settings regulations and advise on how to address any licensing and service provision rules that are in conflict with CMS HCBS settings.	July 1, 2016	December 31, 2016
4	On-site Compliance Reviews	<p>The state will review remediation status updates submitted by providers as required by their CAP. Validation of reports from providers will be done by conducting onsite reviews to monitor compliance. Onsite compliance reviews may be done during the remediation process or following completion of the remediation timelines outlined in the CAP.</p> <p>Onsite compliance reviews occurring during the remediation process will follow the normal HCBS quality assurance review cycle. Recertification reviews are done at one-year or three-year intervals. For periodic reviews, every provider has an onsite review once during a five-year period. For focused reviews, a random selection of providers is taken such that all providers will be reviewed during a five-year cycle. Targeted reviews are done as the result of a complaint made to the IME about a provider, so any time an HCBS Specialist is onsite for a complaint investigation, review of issues related to the settings regulation may be included. With this review cycle, approximately 40% of HCBS providers will have an onsite compliance review in any given year.</p> <p>Providers who are unable to meet the milestones outlined in their CAP may be subject to additional CAPs or may be sanctioned (as described in activity #7 below)</p>	12/1/2014	6/30/2018
5	Data Collection	The state will collect data from assessments and compliance reviews conducted by the HCBS quality assurance unit and the state-contracted MCOs. Data collected will include assessment findings, CAPs issued, and remediation status. This data will be used to track the status of compliance efforts for each	12/1/2014	3/16/2019

		identified setting.		
6	Provider Assessment Findings	The state will present each provider with the results of the assessment of their HCBS settings as findings occur throughout the assessment process outlined in section 2.3.4 of this transition plan.	12/1/2014	3/31/2018
7	Provider Individual Remediation	<p>When a setting is found to be out of compliance at any point in the assessment process outlined in section 2.3.4 of this transition plan, the HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the milestones to be met to remediate issues, the specific timelines for compliance, and the provider's monitoring process to be used to ensure milestones and timelines are met. The state will review the CAP and may accept it or may ask for changes. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question and will allow reasonable timeframes for providers to come into compliance. If a provider's CAP does not address an issue, or does not adequately address an issue, the state may prescribe the remediation requirements necessary to become compliant.</p> <p>Providers will be required to submit periodic status updates on remediation progress. Providers who are unable to meet the milestones outlined in their CAP may be subject to additional CAPs or may be sanctioned (as described in activity #7 below)</p> <p>Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review as described in section 2.3.4.1 of this transition plan.</p>	12/1/2014	6/30/2018
8	Provider Sanctions	<p>The state will sanction providers that have failed to comply with the settings regulation. This will include providers who:</p> <ul style="list-style-type: none"> • Refuse to cooperate with any assessment or remediation activities outlined in this transition plan • Fail to correct any deficiency related to the settings regulation after receiving notice from the IME. This includes but is not limited to providers who fail to submit a CAP, fail to remediate deficiencies in a timely manner as described in the CAP, or fail to remediate all identified deficiencies as described in the CAP. 	12/1/2014	3/16/2019

9	Member Transitions to Compliant Settings	<p>To date, preliminary assessment activities have not identified any settings in which relocation of members will be necessary. In the event that the state determines that a setting cannot be remediated, alternate funding sources will need to be secured for members choosing to remain in the setting. For members who choose to continue receiving HCBS funding in an alternate setting and relocation is necessary, the state will ensure that members are transitioned to settings meeting HCBS settings requirements.</p> <p>The state will utilize its existing provider closure process that uses a collaborative team approach involving the IME, community-based case managers, providers, and advocates to assist members in finding safe and acceptable alternate housing and services. Members are given timely notice and appeal rights related to the closure of the setting. The community-based case manager plays a key role to assure the person centered planning process is utilized so that members have a choice of alternative settings. The case manager is supported by the closure team who provides information and resources about services and supports that may be beneficial to members on a case-by-case basis. Transition of members is comprehensively tracked on a daily basis, to ensure continuity of care. Conference calls with the closure team to monitor transition progress are held at least weekly, with additional calls concerning individual members held as needed.</p>	12/1/2014	3/16/2019
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2.3.6: Monitoring of Settings

Iowa's approach for the monitoring of settings compliance after the March 17, 2019, deadline capitalizes on our existing quality assurance processes which utilize an ongoing process of discovery, remediation, and improvement. Our quality assurance processes, including the annual provider self-assessment, onsite assessment, compliance reviews and remediation activities, will continue to ensure that all HCBS settings which were in compliance by the deadline will continue to meet the requirements on an ongoing basis. If a setting is found to be out of compliance after March 17, 2019, payment to the provider(s) will be terminated for all services rendered in the setting until compliance is demonstrated.