

STATE OF IOWA DEPARTMENT OF
Health AND **Human**
SERVICES

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

MARCH 2023

VERSION 2.0

Contents

I.	Introduction.....	3
II.	Iowa’s Statewide Transition Plan History.....	5
III.	Assurances.....	8
IV.	Overview of HCBS and HCBS Quality Oversight in Iowa.....	10
A.	Programs, Waivers, and Services.....	10
B.	Iowa Administrative Code (IAC) Rules Review.....	14
C.	HCBS Quality Oversight Processes.....	15
1.	Annual Provider Quality Self-Assessment.....	17
2.	Quality Oversight Review.....	19
3.	Complimentary Activities or Evaluation Types.....	22
D.	Building Non-Disability Specific Network Capacity.....	27
V.	Impact of the COVID-19 Public Health Emergency.....	28
VI.	Implementing Iowa’s Statewide Transition Plan.....	30
A.	Settings that are not HCBS.....	34
B.	Settings that are HCBS and presumed compliant.....	34
C.	Settings Required to Be Assessed for Compliance.....	35
D.	Assessing settings.....	37
1.	Assessment through the Provider Quality Self-Assessment, Address Collection, and Attestation.....	37
2.	Assessment through Quality Oversight Review.....	38
3.	Assessment through the Residential Assessment tool.....	39
4.	Settings-Specific Assessment.....	39
F.	Transition process from non-compliant Settings.....	41
1.	Initial Identification of Settings Requiring Heightened Scrutiny.....	42
2.	Ongoing Identification of Settings Requiring Heightened Scrutiny.....	44
3.	Referrals for CMS heightened scrutiny review.....	46
VII.	Validation of Results.....	47
A.	Results from Available Data.....	47
VIII.	Ongoing Monitoring.....	51
IX.	Conclusion.....	52
X.	Attachments.....	52

I. Introduction

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for Home and Community-Based Services (HCBS) that required the State of Iowa to identify all residential and nonresidential settings where HCBS are provided for the purpose of assessing compliance with the final rule. Once identified, Iowa was required to establish a systematic process to review and assess the settings where members receive HCBS to determine if each setting complies with the final rule. For settings that did not initially comply, the State was to identify how each setting could comply and maintain compliance with the final rule. For settings that could not come into compliance, the State was required to establish a process for the timely transition of members into settings that meet the HCBS settings requirements. The time between the establishment of the final rule and the deadline for all states to fully comply is referred to as the “transition period”. The transition period ends on March 17, 2023.

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

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

The final rule makes distinctions between settings where HCBS may be provided. Included are:

- Settings that are HCBS and presumed to meet the final rule without any change required
- Settings that are not HCBS
- Settings required to be assessed for the HCBS setting criteria

Settings requiring assessment for HCBS settings criteria might be found, through assessment and review, to be able to achieve compliance with or without modifications or may be found to be unable or unwilling to achieve compliance. Iowa’s process for identifying settings that require assessment for the HCBS criteria is addressed [here](#).

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

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

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

The Federal regulation also defines settings that require “**heightened scrutiny**”, a term used to describe an enhanced review process, when the setting is presumed to have the qualities of an institution or otherwise isolates individuals receiving HCBS from the broader community. States may perform “first-level” heightened scrutiny reviews and submit the settings and results to CMS for final heightened scrutiny review and approval. CMS may also select settings to review outside of the referrals from the State.

CMS established three categories of settings that require heightened scrutiny.

Category 1: Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

Category 2: Settings in a building on the grounds of, or immediately adjacent to, a public institution.

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

Later, CMS offered additional guidance on the characteristics of Category 3 settings, further defining them as:

- Settings that limit individuals' opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid HCBS due to the design or model of service provision.
- Settings that restrict members' choices to receive services or to engage in activities outside of the setting.
- Settings that are physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services.
- Settings where the individuals in the setting are primarily, or exclusively, people with disabilities and on-site staff provides many services to them.

- Settings designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral, and therapeutic services, social and recreational activities.
- Settings designed specifically for people with disabilities or a specific type of disability.

In late 2018 and early 2019, CMS provided technical guidance to all states around the heightened scrutiny criteria and review process. States were required to identify and assess all settings that met a category of heightened scrutiny and work with providers operating these settings to ensure the setting overcomes the institutional presumption. Meeting a category of heightened scrutiny and receiving a heightened scrutiny review do not disqualify a provider from participating in HCBS. As applicable, providers operating such settings may be required to take corrective action to come into compliance with the final rule.

Per guidance provided by CMS, providers operating settings that met Category 3 of heightened scrutiny that submitted a Corrective Action Plan (CAP) to address compliance issues and fully implemented required changes before July 1, 2021, are not required to be put forward for CMS heightened scrutiny review. However, providers who had not successfully implemented a CAP and come into compliance with the final rule by July 1, 2021, are required to be put forward for a CMS heightened scrutiny review. Settings that meet Categories 1 or 2 are required to be put forward for heightened scrutiny review regardless of whether the State determined the setting has overcome the institutional presumption prior to July 1, 2021.

Guidance was provided by CMS regarding new, presumptively institutional settings such as newly licensed facilities intending to provide HCBS waiver or Habilitation services. These settings require heightened scrutiny review and CMS approval prior to using HCBS funding in the setting. Final heightened scrutiny site approval by CMS must be secured by March 17, 2023. Iowa's process for identifying, assessing, and submitting settings for CMS heightened scrutiny is outlined [here](#).

Iowa may only include these settings in its Medicaid HCBS programs if the setting has been reviewed by Iowa's Quality Improvement Organization (QIO) HCBS Unit and is in full compliance with the HCBS setting rules by March 17, 2023. If the setting is not in compliance by this date, Iowa may only include the setting in its Medicaid programs if CMS determines through a heightened scrutiny process, based on information presented by the State and with input from the public, that the State has demonstrated that the setting meets the qualities for being home and community-based and does not have the qualities of an institution.

States were also to develop a process for the timely transition of members from settings that are unable to achieve compliance. Iowa's plan for transitioning members is described [here](#). Lastly, states must ensure all HCBS settings remain compliant ongoing. Iowa's ongoing quality oversight processes are described [here](#).

II. Iowa's Statewide Transition Plan History

After a period of public comment, the State of Iowa submitted an initial Statewide Transition Plan (STP) to CMS in March 2015 ([Version 1.1](#)) along with plans for each HCBS waiver. CMS provided feedback and identified required changes prior to initial approval. Updates were submitted in January 2016 ([Version 1.2](#)) and April 2016 ([Version 1.3](#)). Iowa took the needed steps to address the technical corrections identified by CMS and was given approval of the initial STP [Version 1.4](#) on August 9, 2016. In the initial STP [approval letter](#), CMS identified actions required of Iowa to receive final approval.

1. Complete comprehensive site-specific assessments of all HCBS settings, implement necessary strategies for validating the assessment results, and include the outcomes of these activities within the STP.
2. Draft remediation strategies and a corresponding timeline that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identified by the end of the HCBS rule transition period.
3. Outline a detailed plan for identifying settings that are presumed to have institutional characteristics, including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating those settings and preparing for the submission to CMS for review under heightened scrutiny.
4. Develop a process for communication with beneficiaries that are currently receiving services in settings that do not or will not come into compliance with the HCBS setting rules by the CMS deadline which is now March 17, 2023.
5. Establish ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

An updated STP ([Version 1.5](#)) was put forward for public comment and submitted to CMS on December 19, 2019. CMS responded with additional guidance for fully implementing the plan in early 2020, just before the breakout of the COVID-19 Public Health Emergency (PHE). To receive final approval, Iowa needs to adequately address the additional questions and feedback.

1. Clarify if residential assessments addressed all HCBS settings criteria, who completes the residential assessments for each of the delivery systems, verify residential assessments are completed without conflict of interest and clarify the response validation process. Explain in detail the self-assessment process including a description of the methodology for “calculating the scores of the self-assessments”, the process for validating responses, and an explanation of how providers not required to submit an annual self-assessment are monitored for compliance with HCBS settings requirements.
2. Clarify the IPES process including whether IPES are completed for both residential and non-residential settings, sampling for the IPES participants, and how responses are tied back to individual settings and the follow-up process for “flagged” responses. Additionally, Iowa is asked to clarify a discrepancy in the number of IPES and explain how the regular review processes, residential assessment process, provider self-assessment process, and IPES responses work together.
3. Clarify the remediation process, also known as “modifications”, corrective action plan (CAP) requirement, or “CAP and compliance”. Specifically, provide details about how Iowa identified settings that comply with HCBS settings requirements after remediation. Provide detailed timelines and milestones for the remediation process that demonstrates that the provider has enough time for the state to verify remediation has occurred before March 17, 2023.
4. Explain how specific types of settings are monitored including private homes, settings in which an individual lives with an unrelated caregiver providing HCBS services, and community locations where supported employment is provided.

5. Regarding employment services, detail the specific number of non-residential supported employment and prevocational settings within the state and, if possible, specify between individual and group supported employment placements.
6. Clarify charts and information in the initial STP regarding how many and what types of settings may become compliant with remediation, how many and what types of settings cannot become compliant.
7. Describe how the state will identify settings (both residential and non-residential) that may have the effect of isolating individuals.
8. Clarify how the state is identifying sites it may present for heightened scrutiny, when it expects to have identified those sites, and when the state expects to put forth evidence for heightened scrutiny review to CMS. It is also recommended by CMS to submit settings for heightened scrutiny review on a rolling basis and to ensure sufficient time for additional remediation or communication processes to be completed by the compliance deadline.
9. Clarify and update the list of settings (12) previously identified by the state as potential referrals for heightened scrutiny review.
10. Clarify the process by which the state will verify remediation has occurred in those 12 settings before the compliance deadline.
11. Provide a detailed description of the state's transition process for settings that cannot come into compliance by the compliance deadline including a description of how members are given notice with associated timeframes, how the state will offer an informed choice of alternative settings through person-centered planning, who is responsible for executing the planning and the process, and a description of how the state will ensure that all critical services and supports are in place in advance of each member's transition.
12. Clarify how many individuals have been relocated to date for the settings that do not and will not comply, and an estimate of the number of members that may be in non-compliant settings.
13. Include a timeline for identification of the settings, notification allowing for ample time for due process and relocation deadlines.
14. Explain what the state of Iowa is doing to build capacity of non-disability-specific settings in the state.
15. Add a key to service abbreviations.
16. Ensure all materials are compliant with Section 508 standards.
17. Explain the impact of the COVID-19 public health emergency on the assessment and review process.

Again, after a period of public comment, internal review by Iowa Medicaid and review by Iowa Medicaid's STP committee, Iowa's STP [Version 1.6](#) was submitted to CMS on July 8, 2022, addressing the questions and feedback. CMS requested additional information. Iowa responded in October 2022. Additional questions and feedback were returned. Full feedback and responses from these timeframes are found in [Attachment B](#).

This submission of Iowa's STP Version 2.0 has been reformatted in alignment with the current Iowa Department of Health and Human Services and Iowa Medicaid style requirements and to ensure

compliance with Section 508 of the Rehabilitation Act. This Final STP Version 2.0 reorganizes and consolidates information provided in previous versions and removes outdated charts and tables per recommendations from CMS. Links to previous versions can be found in [Attachment A](#).

III. Assurances

The State assures full and ongoing compliance with the HCBS setting requirements at 42 CFR Section 441.301(c) (4) (5) and Section 441.710(a) (1) (2) and public input requirements at 42 CFR 441.301(6) (B) (iii) and 42 CFR 441.710(3) (iii) within the specified timeframes for the identified actions and deliverables. While the State is already compliant with some of the requirements, the State has or will reach full compliance by implementing a Statewide Transition Plan as described in subsequent sections.

The State assures that, as the standards and the plan for transition are developed, the public has an opportunity for input. The State will consider those comments and revise the plan, as appropriate, before the plan is considered final. This section outlines the public comments received from the July 2022 STP Version 1.6 public comment period along with Iowa's responses. Public comments and responses for all previous versions can be found in the corresponding STP. Links to all published STP are found in [Attachment A](#). Raw public comments from all public comment periods were emailed to CMS on November 2, 2022.

Comment period for Public Notice and Tribal Notice closed at 4:30 pm on July 5, 2022. Four comments were received. Two were not applicable to the STP. Two were related to CMS guidance on flexibilities related to compliance with settings criteria that is directly impacted by the PHE, including PHE-related workforce challenges.

Comments Summary

Two comments received expressed concern that STP Version 1.6 did not address how the workforce shortage will affect providers' ability to comply fully with all settings criteria and suggested Iowa take the opportunity to submit a Corrective Action Plan (CAP) allowing for extra time to fully comply, per CMS guidance in May 2022. One comment suggested that assisted living regulations be changed to allow admittance of individuals with specific transferring needs. One comment questioned if there will be a point in time when services needed for long-term, in-home care will be provided without the need for an Exception to Policy.

Comment #1

Why does the final HCBS STP not address how the workforce shortage will affect providers' ability to comply fully with all settings criteria? Per guidance released by CMS in May 2022, there is an understanding from CMS that several settings criteria are directly affected by the workforce shortage – access to the broader community; opportunities for employment; choice in roommates; and choice in non-disability-specific settings. CMS also acknowledges that providers may not be in full compliance due to the workforce shortage. CMS offered the option for states to request a CAP by 12.1.2022 for these workforce-dependent expectations. While the STP does reference the barriers for providers during the PHE, it does not provide any latitude or guidance for providers in this area, instead stating providers must be in full compliance with the Final Rule by March 2023. Given that CMS acknowledges the PHE-related workforce shortage is a barrier to full compliance with the Final Rule, we would like to see some

language in the STP offering providers additional latitude to fully comply with workforce-dependent criteria.

Comment #2

After reviewing the final HCBS Settings STP, we are left with a question regarding the CMS settings expectations related to the workforce shortage resulting from the PHE. Per guidance released by CMS in May 2022, there is an understanding from CMS that expectations in the Final Rule that have been directly impacted by the PHE – access to the broader community; opportunities for employment; choice in roommates; and choice in non-disability specific settings – may not be in compliance due to the workforce shortage. CMS offered the option for states to request a CAP by 12.1.2022 for these PHE-related expectations. While the STP does reference the barriers for providers during the PHE, it does not provide any latitude or guidance for providers in this area, instead stating providers must be in full compliance with the Final Rule by the March 2023 deadline. Though there seems to be an awareness the PHE-related workforce shortage is a barrier to full compliance with the Final Rule, it is unsettling to see the STP state, “As the PHE unwinds and providers reestablish ‘typical’ business practices...” as though the end of the PHE solves the issue, without any further statements indicating a recognition this will be a longer-term barrier. We would like to see some additional language in the STP indicating an understanding that providers may not be in full compliance with non-PHE related expectations due to the workforce shortage and how this will be addressed.

Response

Iowa recognizes the impact of the PHE and PHE-related workforce challenges on the state’s and individual providers’ ability to fully comply with certain criteria. Iowa reserves the opportunity to submit a CAP until the final version of this STP is received and feedback is provided from CMS. See sections labeled “new section based on public comment” on pages 18-21 [of STP Version 1.6] for further explanation.

Comment # 3

The general comment is that the change in language from "consumer-centered" to "person-centered" in the Iowa Administrative Code is most appropriate and much appreciated. Human beings are so much more than mere material units of economic activity.

The specific comment is about Assisted Living Facilities. I am finding that Assisted Living Facilities (ALFs) will not take me because I use a Hoyer lift for transfers. Thus, that is a barrier to community integration, or reintegration, for folks like myself, and additionally raises the question of whether ALFs can truly be considered as HCBS settings. To remedy this egregious discrepancy in the most positive way, ALFs should be permitted or required to accept residents who transfer by Hoyer so that those facilities may attain full HCBS setting compliance.

Response

The HCBS settings regulation requires that settings where HCBS are provided are accessible to the members within the setting. Iowa has determined that assisted living facilities are accessible to the members eligible to receive HCBS and live in an assisted living setting.

Comment #4

I am wondering if we will ever reach a point where services needed for long term in home care will be provided without the need for ETP’s...

Response

The context of the comment is unclear and does not appear to relate directly to the STP.

IV. Overview of HCBS and HCBS Quality Oversight in Iowa

Iowa has a long history of providing HCBS waiver and Habilitation support and services to members that support the member's choice in where and with whom they live. Prior to July 1, 1992, when the Intellectual Disability (ID) Waiver began, all residential HCBS waiver services were provided in the member's home or within the greater community in which they lived. With the creation of the ID Waiver in 1992 and later the Brain Injury (BI) Waiver and State Plan HCBS Habilitation program, provision of residential services in provider owned or 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 three to four members that were fully integrated into the local community. Supports and services were provided in the living environment where the member chose to live. Waiver service provider agreements were established, separate from lease agreements, allowing a member the freedom to move to a setting of their choice or to choose whether or not to live with different housemates knowing that their assessed service needs would be provided in any community-based setting of their choice.

A. PROGRAMS, WAIVERS, AND SERVICES

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

HCBS Habilitation Services (1915(i)) – provides services and supports for Iowans with the functional impairments typically associated with severe and persistent mental illnesses. There are no age limitations for this program. However, the program provides the type of services typically needed by adults with a chronic mental illness.

These are the services that may be funded by this program:

- Home-Based Habilitation (HBH)
- Day Habilitation
- Prevocational Services
- Supported Employment
- Case Management

AIDS/HIV Waiver (CMS Waiver # IA.0 213) – provides services for persons who have been diagnosed with AIDS or HIV and who meet the hospital or nursing facility level of care. There are no age limitations for this program.

These are the services that may be funded by this waiver:

- Adult Day Care

- Consumer-Directed Attendant Care (CDAC)
- Counseling Services
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Nursing
- Respite

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

These are the services that may be funded by this waiver:

- Adult Day Care
- Behavioral Programming
- Case Management
- CDAC
- Family Counseling and Training
- Home and Vehicle Modification
- Interim Medical Monitoring and Treatment (IMMT)
- Personal Emergency Response
- Prevocational Services
- Respite
- Specialized Medical Equipment
- Supported Community Living (SCL)
- Supported Employment
- Transportation

Children’s Mental Health Waiver (CMS Waiver # IA.0819) – provides services for children who have been diagnosed with serious emotional disturbance who meet the level of care provided in a psychiatric hospital serving children under the age of 21. Members must be under 18 years of age for this waiver.

These are the services that may be funded by this waiver:

- Environmental Modifications and Adaptive Devices
- Family and Community Support Services

- In-Home Family Therapy
- Respite

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

These are the services that may be funded by this waiver:

- Adult Day Care
- Assistive Devices
- Assisted Living Service
- Case Management
- Chore
- CDAC
- Home and Vehicle Modification
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Mental Health Outreach
- Nursing
- Nutritional Counseling
- Personal Emergency Response
- Respite
- Senior Companion
- Transportation

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

These are the services that may be funded by this waiver:

- Adult Day Care
- Homemaker
- CDAC
- Counseling
- IMMT
- Home and Vehicle Modification

- Nursing
- Nutritional Counseling
- Home Delivered Meals
- Personal Emergency Response
- Home Health Aide
- Respite

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

These are the services that may be funded by this waiver:

- Adult Day Care
- CDAC
- Day Habilitation
- Home and Vehicle Modification
- Home Health Aide
- IMMT
- Nursing
- Personal Emergency Response
- Prevocational Services
- Respite
- SCL
- Residential Based Supported Community Living for children (RBSCCL)
- Supported Employment
- Transportation

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

These are the services that may be funded by this waiver:

- CDAC
- Home and Vehicle Modification
- Personal Emergency Response
- Specialized Medical Equipment

- Transportation

B. IOWA ADMINISTRATIVE CODE (IAC) RULES REVIEW

One of Iowa's first steps in the implementation of the final rule was to analyze existing Iowa Administrative Code (IAC) for congruence with the HCBS settings requirements. This would allow Iowa to align all quality oversight processes with settings requirements going forward. The IAC chapters applicable to the 1915(c) HCBS waiver and 1915(i) Habilitation programs include:

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

It was identified that, as a whole, the four IAC chapters listed above support HCBS members receiving services in integrated community-based settings. The State identified the rules support a member to have choice and control in the services and supports they receive. The state identified that the rules of the HCBS program have been periodically updated over time to reflect the addition of new services, new HCBS waiver programs and changes to the Habilitation program, and regulation changes at the State and Federal level.

The rules analysis also identified rules that required amending to support full implementation of the federal setting regulations. For example, it was identified that additional rule development was necessary 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. IAC did 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.

Additionally, IAC for HCBS was silent on members having lockable doors to living and sleeping units. As such, rules were promulgated in IAC 441- 77.25(5) to assure that members can lock entrance doors to their home or to their individual sleeping units with appropriate staff having access to keys to the locks as needed to assure member health and safety.

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

IAC rules originally did not address physical accessibility in residential settings. Rules were promulgated in IAC 441-77.25(5) to assure that all provider-owned, or controlled settings meet the physical accessibility needs of the members living in the setting.

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

Based on the initial rules analysis, Iowa Medicaid developed a notice of intended action for HCBS settings regulations under ARC 3784C. The rules were written and posted for thirty days to allow for public comment and approved by the legislative rules committee. The rules were promulgated effective August 8, 2018. The attached notice of intended actions details the activities conducted to promulgate the HCBS Settings rules were taken. See [Attachment J](#) for details of ARC 3784C.

C. HCBS QUALITY OVERSIGHT PROCESSES

Iowa has had a robust HCBS quality oversight system in place for over thirty years. This quality oversight system includes regular, ongoing review of providers of HCBS waiver and Habilitation services. Iowa Medicaid maintains a contract for the Quality Improvement Organization (QIO) HCBS Unit through a request for proposal process. The QIO HCBS Unit is responsible for all quality oversight activities for the HCBS waiver and Habilitation programs, including the review and assessment of HCBS settings. While there are multiple entities responsible for generating and gathering HCBS settings information and data (i.e., case managers and MCO), the QIO HCBS Unit is responsible for coordinating quality assurance activities and reporting to Iowa Medicaid. Currently, Iowa Medicaid contracts with Telligen, Inc. to conduct the quality oversight activities of the HCBS waiver and Habilitation programs.

Not all services under each waiver or Habilitation program are subject to quality oversight review by the QIO HCBS Unit. The following services are subject to quality oversight which includes, but is not limited to, annual self-assessment, Periodic or Certification Review, Focused Review, and Targeted Review. In previous versions of the STP, this information was partially displayed in a color-coded table along with other information. Due to inability to make the table accessible and effectively demonstrate all the information, this information depicting the services under each program that are subject to quality oversight has been moved and displayed as a list.

HCBS Habilitation Services

- HBH
- Day Habilitation
- Prevocational Services and Career Exploration
- Supported Employment

AIDS/HIV Waiver

- Adult Day Care
- CDAC provided by an agency
- Counseling Services
- Respite

Brain Injury Waiver

- Adult Day Care
- Behavioral Programming
- CDAC provided by an agency
- Family Counseling and Training
- IMMT
- Prevocational Services
- Respite
- Supported Community Living (SCL)
- Supported Employment

Children’s Mental Health Waiver

- Family and Community Support Services
- In-Home Family Therapy
- Respite

Elderly Waiver

- Adult Day Care
- Assisted Living Service
- Case Management
- CDAC provided by an agency
- Mental Health Outreach
- Respite

Health and Disability Waiver

- Adult Day Care
- CDAC provided by an agency
- Counseling
- IMMT
- Respite

Intellectual Disability Waiver

- Adult Day Care
- CDAC provided by an agency
- Day Habilitation
- IMMT

- Prevocational Services
- Respite
- SCL
- Residential Based Supported Community Living for children (RBSCL)
- Supported Employment

Physical Disability

- CDAC provided by an agency

At the core of quality oversight are the four main review types: Provider Quality Self-Assessment, Periodic or Certification Reviews, Focused Reviews, and Targeted Reviews. Other quality oversight activities complement or contribute to these main review processes such as the address collection process, provider application review, participant experience surveys, Residential Assessments, incident and complaint data, and site-specific evaluations (also known as Settings Assessments).

The QIO HCBS quality oversight structure is primarily built for quality review of providers and the HCBS waiver and Habilitation services they provide, as opposed to quality review of specific locations where they provide services. However, compliance within specific settings is assured through review of a statically valid number of member records which includes review of the settings where the member receives services. Additionally, Residential Assessments administered by the member’s case manager are completed with each member at least annually. Residential Assessments are a means of evaluating the specific member’s residence for compliance. Lastly, providers attest to compliance in every setting where they provide the identified services through the annual Provider Quality Self-Assessment. These activities are described in more detail in subsequent sections.

Providers may be enrolled for multiple services and, although they have a “main office”, they may operate many sites for each of the services they are enrolled to provide, serving many members across the State. Some providers of certain services need “certification” from the QIO HCBS Unit to be eligible to enroll and provide the service. Others are eligible for enrollment with Iowa Medicaid because of external licensing, certification or accreditation and are simply subject to quality oversight from the QIO HCBS Unit. Every provider subject to HCBS quality oversight is selected for a Periodic or Certification Review at least once per five-year cycle or according to their certification end date. Every provider subject to HCBS quality oversight is selected for a Focused Review at least once per five-year cycle. Providers only receive a Targeted Review if there is a complaint or incident requiring this type of review. Every provider of the services listed above must submit the annual Provider Quality Self-Assessment.

Most quality oversight processes existed prior to the implementation of the HCBS setting final rule but may have been leveraged, expanded, or enhanced as tools to assist in determining compliance with HCBS settings requirements. Each quality oversight review type and the complimentary processes are further explained in the next section.

I. ANNUAL PROVIDER QUALITY SELF-ASSESSMENT

In the early 2000s, Iowa Medicaid implemented an annual Provider Quality Self-Assessment to enhance the regular, ongoing review of providers. The HCBS Provider Quality Self-Assessment (SA) form 470-4547 ([Attachment D](#)) is a multifunctional tool that encompasses a checklist for providers to follow in

assessing their own compliance with all applicable requirements pursuant to the Code of Federal Regulations (CFR), Iowa Code (IC), Iowa Administrative Code (IAC) and other standards and best practices. All HCBS waiver and Habilitation providers providing services that are subject to the HCBS settings standards must complete an SA at enrollment and annually. Completed SA are submitted to the QIO HCBS Unit for quality assurance review and approval, but responses are not fully validated and verified until the provider's next quality oversight Periodic or Certification Review. The SA are unique in the overall quality oversight structure since they are both a review type and a complementary process to the other quality oversight reviews. The SA is also said to be the "foundation" of quality oversight reviews as the review checklists are built from the SA and the review processes are used to validate the provider's attestation to the accuracy of their SA responses.

With the introduction of the HCBS settings requirements in 2014, subsequent, Provider Quality Self-Assessments were updated to include criteria related to HCBS settings requirements and the Address Collection Tool was established as part of the self-assessment, as a means of collecting the specific sites where certain HCB services are provided. The current Address Collection Tool can be found in [Attachment E](#). Updates and enhancements to the address collection process and form are described in more detail [here](#).

Quality oversight review checklists already corresponded directly to the self-assessment tool and were expanded to include review of settings requirements in late 2014. In 2018, the settings requirement section was refined to separate requirements for provider owned or controlled residential settings from general settings requirements.

The SA is updated annually and typically released in October with completed forms due back in December each year. Extensions for up to ninety days after the due date are traditionally allowed. Providers failing to submit the SA receive a series of delinquent notices urging them to submit within ten days of the letter before they are referred to Iowa's Program Integrity Unit for sanctions.

The SA includes questions about policies, procedures, and systems the provider has in place for meeting settings requirements in all environments where they provide the identified HCB waiver and Habilitation services as a whole but does not ask each question for each environment. Providers indicating "No" to meeting a standard must also provide a Corrective Action Plan (CAP), implementable within 30 days, outlining how they will come into compliance with the standard. The provider's QIO HCBS Specialist reviews each submission for completeness and accuracy. Discrepancies and inadequate CAP are resolved prior to acceptance of the provider's annual SA. Successful implementation of identified CAP are reviewed with the next annual self-assessment or through a regular review process, whichever comes first. Self-assessment CAP are typically related to correcting a systemic issue in all settings where the provider provides the identified HCB waiver and Habilitation services but on occasion, the identified issue and subsequent CAP may be specific to a setting or type of setting operated by the provider. For example, the provider may operate multiple settings where they provide SCL services such as provider owned or controlled houses and in an RCF. The provider may identify through self-assessment an area of non-compliance in just the RCF setting. Therefore, the CAP would be specific to correcting the issue in that setting.

The current SA form has several sections as follows.

- Organization details such as the provider's contact information.
- Identification of each service subject to quality oversight that the provider is enrolled to provide.

- The self-assessment questionnaire and checklist which asks providers to self-evaluate for the following standards required by law, rule, industry standards, or best practice.
- Organization standards such as the organization’s purpose and mission, fiscal accountability, organizational oversight, and quality improvement processes.
- Personnel and training requirements to ensure the provider’s employees are qualified commensurate with the needs of the members served and requirements for the employee’s position including training on the philosophy of HCBS and HCBS settings requirements and expectations.
- Organization policies and procedures based on the services for which the provider is enrolled to provide. As policies and procedures are the foundation of an organization’s performance and guide them in the provision of services, they should outline the organization’s day-to-day operations, ensure compliance with laws and regulations, and give guidance to staff. Organizations must carry out their policies and procedures so that members receive fair, equal, consistent, and positive service experiences.
- HCBS settings self-evaluation of each standard in all settings where the selected services are provided.

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

2. QUALITY OVERSIGHT REVIEW

Quality oversight reviews are conducted by the QIO HCBS Unit to ensure provider compliance with all applicable requirements pursuant to the CFR, Iowa Code, IAC and other standards and best practices. As stated previously, quality oversight review includes the following main review types aside from the annual SA: Periodic or Certification Reviews, Focused Reviews, and Targeted Reviews.

Periodic Reviews: All non-certified providers receive a Periodic Review at least once in a five-year cycle. During the review process, responses on the latest SA are verified to evidence found in member and personnel records and compared to other evidence such as Residential Assessments for selected members, any participant experiences surveys completed with selected members in the last year and more.

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

process is the same as the Periodic Review process but results in a score that determines the provider's certification level.

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

Focused Reviews: Providers are semi-randomly selected each year to participate in a Focused Review, and all providers receive a Focused Review once in a five-year cycle. The Focused Review subject is determined annually and based on historical data and Iowa Medicaid need. The State Fiscal Year (SFY) 2017 and 2018 focus topic was HCBS setting readiness and compliance in non-residential settings. The SFY23 topic is HCBS settings compliance in residential settings including verification of responses on selected members' most recent Residential Assessment.

Periodic or Certification and Focused quality oversight reviews begin with a notification to the provider that a review has been initiated. In the initial notification, the provider's policies and procedures for HCBS, current quality improvement plans and latest quality improvement reports are requested in addition to current member information and current staff information. The provider returns these materials to the HCBS Specialist. The HCBS Specialist selects a representative sample of members and staff to review. Beginning in July 2022, the HCBS Specialist also reviews the member list and latest address collection tool and selects non-residential and provider-owned or controlled residential locations to tour and assess for compliance with HCBS settings requirements.

Another notification is sent to the provider outlining the selections and alerting the provider of what to have available when the HCBS Specialist comes onsite for the review. This notice also lets the provider know that the HCBS Specialist will be working with them to schedule tours of the selected sites.

Between the initial notification and the onsite review, the HCBS Specialist gathers other evidence to contribute to the review process including the provider's latest SA, any incidents and complaints information specific to the provider or members selected for the review, the latest Residential Assessments for the selected members, any participant experience surveys completed with the selected members in the last year, and any Settings Assessments that might have been completed in the last year for settings operated by the provider.

In the weeks and days prior to the onsite review, the HCBS Specialist reviews the submitted policies and procedures, quality improvement information and any other information gathered ahead of time. The HCBS Specialist may also complete some or all the tours ahead of the onsite review. The HCBS Specialist may choose to use the Settings Assessment tool to guide the tours and provide a place to take notes about their observations and conversations with agency staff and leadership that occurs during the tours.

The onsite review is then completed, typically in the main office of the provider. During the onsite review, the records of the selected members (including service documentation) and personnel and training records of the selected staff are reviewed. The Periodic, Certification, or Focused Review checklist are used to guide the review which is based on the same Provider Quality Self-Assessment tool.

After the onsite review, additional tours might need to be completed and the provider is allowed some additional time, usually up to five days, to submit supplementary information or information that was not

made available at the onsite review. During this time, the HCBS Specialist compares findings from all pieces of evidence, determines outcomes, finalizes checklists, and writes a narrative report outlining findings and supporting findings with evidence. The checklists identify when a corrective action plan is required, and the narrative outlines the rationale behind it. Additionally, the report may offer accommodations where the provider has exceeded basic compliance and demonstrated quality above and beyond best practice. Lastly, the report may outline recommendations for providers in developing a CAP or for general improvement in a certain area. The completed checklist and narrative report are sent to the provider within thirty days of the conclusion of the review.

The infographic below shows how the review process incorporates all pieces of evidence including the complimentary activities and evaluation types outlined in the next section. These independent activities and processes are used as evidence to determine compliance with all State and Federal requirements. At the same time, findings from some of the processes are used to validate and verify each other. To validate and verify answers, QIO HCBS Specialists look at the provider's policies, procedures, quality improvement plans, and records in addition to any other available evidence such as incident and complaint data, site tours, and any existing member experience surveys. Evidence is compared and discrepancies are addressed through the Periodic or Certification Review, possibly resulting in corrective action.

When a Corrective Action Plan (CAP) is required, including corrective action related to HCBS settings requirements, the provider is given thirty days from the receipt of the report outlining the CAP requirements to respond with their plan for remediating the issue and coming into compliance. Once a CAP is accepted, the provider has sixty days to carry it out before the QIO HCBS Unit initiates a follow-up compliance review. The compliance review will include review of any evidence necessary to ensure the CAP was successfully carried out and to demonstrate that the provider is now in compliance.

Components of Quality Oversight Review



3. COMPLIMENTARY ACTIVITIES OR EVALUATION TYPES

The Home and Community Based Services (HCBS) Residential Setting Member Assessment form 470- 5466 ([Attachment C](#)) is used as a tool to assess, discover, and remediate HCBS settings issues in residential sites and with individual members. The tool is to be administered at least annually by a member’s Integrated Health Home (IHH) care coordinator, case manager, or MCO community-based case manager, hereby referred to as “case manager”, to assess a member’s place of residence for compliance with the setting rules. Since every HCBS waiver and Habilitation member receives a Residential Assessment at least annually, every residential setting where HCBS waiver and Habilitation services are provided is evaluated for compliance with settings requirements.

Completing the Residential Assessment requires knowledge of the member, their living situation, and the services received. Case managers administer the Residential Assessment with members because they are already required to meet with the member face-to-face in their place of residence at least quarterly and because a case manager is likely to have more familiarity with the member’s ongoing life and living situation. Administration of the Residential Assessment requires a conversation with the member, their legal representatives and provider staff, as appropriate, to determine member outcomes. Responses

come directly from the member with some influence from the case manager's professional observation and knowledge of the member's communication style and abilities.

The HCBS Residential Assessment form is composed of four sections: demographics, instructions, member outcomes, and final outcomes. The Residential Assessment form identifies if a member will complete a partial or full assessment. Members who live with their family, own their own home, or rent a living unit from a community landlord that is not owned, operated, or controlled by an HCBS service provider, are presumed to live in integrated community settings and are required to complete a partial assessment. All other members are required to complete the full assessment.

The full assessment includes nine member outcomes designed to assist with identifying the member's experience living in a community setting and using community resources.

The nine-member personal outcomes include:

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

The nine-member personal outcomes are expected to be present in a member's life. Each outcome is listed separately and has a series of questions for the case manager to ask or observe as they talk with the member, family, or provider staff, to assist with determining how the member personally defines the outcome and whether the outcome is present in the life of the member. The presence of the nine personal outcomes identifies characteristics of living in integrated community settings. There is no right or wrong answer to the outcome questions as the outcome is defined by the member as it applies to their life in the community and identifies the experience of the member living in their residential setting.

The list of questions included on the residential assessment form are not exhaustive and the case manager may ask additional questions based on their observations in the residence and responses from the member and others present during the assessment. The interview must include the member and may include others with knowledge of the member's needs and preferences (parents, guardians, provider staff, etc.) if the member is unable to comprehend or respond to the questions because of a cognitive, verbal, or other impairment. By asking the questions, the case manager must have enough information to answer either yes or no on the final outcome question at the end of each outcome section. If the case manager cannot make a final determination, additional guidance questions are needed. For each Yes or No response, the case manager must provide evidence that supports the final response.

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

determine if the member has access to and uses the resources of the community in which they live to the degree desired by the member. The three questions/outcomes are:

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

The HCBS Residential Setting Member Assessment is submitted to Iowa Medicaid by the member's case manager through Iowa Medicaid's Portal Access (IMPA). On a monthly basis the QIO HCBS Unit pulls a data report from IMPA identifying completed residential assessments for the past month. Members that have a "No" response to any of the above three final assessment questions are marked for follow up with the member's case manager by the QIO HCBS Unit.

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

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

Residential Assessments are used as a piece of evidence in quality oversight Periodic or Certification, and some Focused Reviews meaning the most recent Residential Assessment is pulled for members selected for quality oversight reviews. The selected members' responses, especially "flagged" responses as described above, are reviewed and compared to other pieces of evidence such as responses on the provider's latest SA, the provider's policies and procedures, and other evidence found in the member records. In that way, the Residential Assessment can be used to validate and verify the provider's responses on their last SA and vice versa. Discrepancies are addressed through the review process, possibly resulting in corrective action.

The HCBS Waiver and Habilitation Settings Assessment tool ([Attachment F](#)) is also known as site-specific evaluations and is used to evaluate specific residential and non-residential sites and locations for compliance with settings requirements. This tool is used by QIO HCBS Specialists to document and organize results of site-specific tours and reviews. The questions on the settings assessment tool come from the Provider Quality Self-Assessment settings section and also correspond

to the Periodic and Certification Review checklists. The tool may also be used as a stand-alone evaluation tool for special circumstances. A provider's specific residential or non-residential location may be selected for a setting assessment based on a potential concern related to HCBS settings requirements.

A potential concern that may result in a settings-specific assessment may be discovered through the SA and address collection process, regular quality oversight reviews, Residential Assessment responses, incidents or complaints related to HCBS settings requirements, and any other member-specific compliance concern. The QIO HCBS Unit may also be alerted to a setting requiring a setting assessment from an outside party such as another state unit, an MCO, or community member. Responses to Iowa's Participant Experience Survey (IPES) tool may also be used to discover a potential setting requiring this specialized evaluation.

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

The Iowa Participant Experience Survey (IPES) is a customized version of the Participant Experience Survey (PES) tools developed by CMS for use with HCBS programs. The IPES is conducted by the QIO HCBS Unit for the FFS populations and each MCO for their enrolled members.

The number of IPES needed to maintain a statically valid sample is determined each year based on waiver and Habilitation enrollment and in keeping with the number necessary to complete by the end of the year. Members selected for the IPES may be receiving any combination of services offered by their prospective waiver or Habilitation program. Some members selected for the IPES may not be receiving any services subject to setting requirements or even quality oversight review. Others may be receiving several services that are both subject to quality oversight review and settings requirements. Participation in the IPES is voluntary and members have the right to decline the survey. Participants are asked a series of questions related to their experience planning for services and experiences with the providers they are using.

IPES has been used by Iowa to understand member's experiences with HCBS for several years, but it was noted at the inception of the final rule that there are questions on the survey that could give Iowa some baseline data for how the State was complying with HCBS settings requirements based on the member experience with services. For example, the survey includes questions such as:

- Do you feel you get to choose the things you do with your life?
- Do you feel you understand your rights?
- Were other agencies talked about before your providers were chosen?
- Does someone help you if you don't understand your rights?

- When a staff person is working with you, they should respect your rights. Staff can only limit your rights if you agree to it. Has staff stopped you from doing something you want to do?
- Have you had to change a service provider/agency that you were working with?
- Do you feel you have a part in planning your services?
- Were you given a list or told the names of different services providers you could use?
- There are different ways to calm a person down with restraint. Some of the ways include medicine, a shot, being held down, or being strapped down. Has this happened to you in the past two years?
 - Have you told anyone on your team this happened?
 - Has the plan been written telling others how to you if you become upset?
- Did you decide to use this/these services providers?
- Have you told anyone on your team you would more choice in picking the things you do?

Results of Iowa's initial analysis of this data can be found in STP ([Version 1.4](#)) starting on page 56. The graphs reflect responses to questions related to individual initiative, autonomy, and independence in making life choices. It was generally determined that the majority of members receiving HCBS felt they had a 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 knew their rights and that their rights are respected.

The IPES was an existing survey prior to the HCBS settings final rule and is not limited to members receiving services subject to quality oversight or in settings subject to the final rule. It was therefore not intended to be a strategy for validating providers' responses on the SA or as a site-specific assessment tool. That being said, the IPES has since been added as a piece of evidence in quality oversight Periodic or Certification, and some Focused Reviews meaning that IPES are pulled for members selected for quality oversight reviews if one has been completed with the selected members in the last year. If one exists for the selected members, their answers are reviewed and compared to other pieces of evidence such as responses on the latest SA, evidence found in member and personnel records and compared to other evidence as previously identified. In that way, although it was not originally intended for this purpose, the IPES may act as one way to verify responses on the provider's SA. Discrepancies are addressed through the review process, possibly resulting in corrective action.

Immediate concerns found through the IPES at the time the IPES is being completed with the member, are addressed through the established IPES "flag" process. When a member indicates a negative response to certain questions, the response is "flagged" for follow-up. Follow-up on a flagged question means the interviewer or designee contacts the member's case manager to explain the member's response and request that the case manager provide an explanation and remediation plan to the identified issue. The case manager typically must contact the member or their legal representative to talk about the member's response and determine a need for any additional education, plan updates, or other action to resolve the issue. An explanation or remediation plan must be provided within thirty days. The explanation or remediation plan is reviewed by a QIO HCBS Specialist to ensure the "flagged" concerns have been appropriately resolved. The QIO HCBS Specialist will work with the case manager until the "flagged" issue is remediated appropriately. While the IPES flagged questions are not specific to settings requirements, occasionally, responses may be tied back to a specific setting and related to HCBS

settings requirements. For example, in completing the survey, a member could reveal that staff are unduly restricting their rights in a residential, provider-owned or controlled setting. In that case, the issue would be tied to specific setting and would be referred to the case manager for follow-up and remediation. Again, while IPES was not initially designed as a site-specific evaluation tool, there are times that it may reveal individual member issues in a specific setting.

D. BUILDING NON-DISABILITY SPECIFIC NETWORK CAPACITY

Currently members using HCBS waiver and Habilitation services have options to access residential and nonresidential services in non-disability specific community settings. This includes accessing services in residential settings that are typical types of housing available to anyone living in a community as well as non-residential settings that are fully integrated into community settings.

Most members accessing HCBS services live in residential settings that are neither provider owned or controlled nor licensed facilities. Residential options for members accessing HCBS may include living with family or friends, renting from community landlords, or owning their own home. These options allow members to receive services in their own home and within the community of their choice and allows members to have access to other non-disability specific community resources like grocery stores, shopping malls, churches, sporting events, restaurants, parks, and other entertainment settings and venues to which all individuals of the community have access.

The HCBS program has worked with the Iowa Finance Authority (IFA) to assist members to access rental assistance in community-based housing. The IFA has been administering the Home and Community-Based Services (HCBS) Rent Subsidy Program since January 2005. This program provides temporary rental assistance for people who receive medical services through Medicaid 1915 (c) waivers until the person becomes eligible for another public or private rent subsidy.

The QIO HCBS Unit has worked with non-residential providers to decrease reliance on center-based service provision. For example, throughout the transition period, some providers of day habilitation services developed 100% community-based or "no walls" day habilitation program models where members meet in the community and access the community throughout the entire service. When day habilitation is delivered in this manner, there is no centralized location or specific site where the services take place. Prior to the COVID-19 public health emergency, some providers of day habilitation services implemented programs that were entirely "no walls" while others offered this type of day service in addition to center-based activities.

Iowa Administrative Code (IAC) rules for HCBS day habilitation service have been changed to expand opportunities and support for community inclusion and develop skills for active participation in integrated community employment. Prior to this rule change, the day habilitation services focused on community inclusion and participation in recreational activities and volunteering opportunities. Adding employment opportunities to the day habilitation service has expanded member opportunity to receive day habilitation services in non-disability specific employment settings in addition to community based recreational settings.

Supported employment settings are required to be integrated community settings where members receive employment supports in community businesses. These employment settings are based on the member's work interest and allows them develop work skills in non-disability work settings.

The Consumer Choices Options (CCO) is a self-direction program available through six of the Iowa's seven 1915(c) waivers. Members using the CCO hire and direct their own care providers and control an

HCBS budget to purchase goods and services to meet their assessed needs. CCO offers more choice, control and flexibility over services and who provides them. Using CCO supports a member to receive services in their home and community of choice and decreases reliance on receiving services from an HCBS provider. Approximately 11% of eligible members choose to use CCO to self-direct some or all their HCB waiver services.

While Iowa has taken some action to assure members have access to non-disability specific settings during the provision of HCBS, the State continues the delivery of HCBS to assure compliance with the settings regulations and expand opportunities to access services in non-disability specific setting. By December 31, 2023, the QIO HCBS Unit will evaluate the current HCBS providers and analyze the findings to identify service delivery options that will encourage more community integration, member autonomy, and choice of non-disability specific settings for individual members. Based on the evaluation and analysis, the QIO HCBS unit will develop and present training materials to providers and case managers to increase understanding and use of non-disability specific settings in the provision of HCBS services.

V. Impact of the COVID-19 Public Health Emergency

The next section details Iowa's implementation of the approved STP by employing existing processes and enhancing, expanding, and creating new processes where gaps existed. Before that, it is important to address the impact that the COVID-19 Public Health Emergency (PHE) and subsequent PHE workforce challenges have had on Iowa's quality oversight and review activities and implementation of the STP.

Onsite reviews were suspended from mid-March 2020 until July 2021. All reviews were completed as desk reviews which impacted the ability to tour sites and to access full records. This caused a significant increase in administrative burden for the provider and the QIO HCBS Unit to complete a review. Although there has been a return to onsite reviews, providers faced with PHE-related workforce challenges have been forced to utilize administrative and leadership staff in direct service roles to meet the needs of members. It has therefore been increasingly difficult for providers to respond to quality oversight and review requirements timely and adequately.

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

Although it is the expectation of CMS that all states and settings be fully compliant with the regulatory settings criteria by March 17, 2023, CMS addressed the difference between criteria that is directly

impacted by PHE disruptions, including PHE-related workforce challenges and criteria that are not impacted.

Settings criteria that are NOT considered to be directly impacted by the PHE, including related workforce challenges include:

- Standards related to members' rights to privacy, dignity, respect, and freedom from coercion and restraint.
- Standards related to members' control of their personal resources.
- Standards related to leases and other legally enforceable agreements providing similar protections.
- Standards related to members' privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
- Standards related to members' access to food at any time.
- Standards related to members' access to visitors at any time.
- Physical accessibility of the member's environment.
- Person-centered service plan documentation of modifications to relevant regulatory criteria.

Examples of settings criteria that may be directly impacted by the PHE, including related workforce challenges, include:

- Standards related to accessing the broader community.
- Opportunities for employment.
- Options for a private unit and/or choice of a roommate.
- Choices of non-disability specific settings.

CMS further allowed states to submit Corrective Action Plans (CAP) to request additional time to achieve full compliance with settings criteria that are directly impacted by PHE. Authorized CAP will allow states to continue receiving Federal reimbursement of HCBS beyond the end of the transition period. To be authorized, a CAP must show that the state's policies and procedures reflect the settings criteria, that the state is compliant with all other settings criteria, and that the state has made efforts to implement the criteria to the fullest extent possible. The state must work with CMS to develop and implement a concrete, time-limited plan to come into full compliance with remaining criteria.

Iowa submitted a CAP to CMS on December 1, 2022. In the CAP it was explained that Iowa anticipates full compliance will be achieved in all HCBS settings by March 17, 2023. However, in the event that CMS determines through heightened scrutiny review or another CMS evaluation process that one or more of Iowa's HCBS settings is not compliant, Iowa will need additional time to respond and achieve compliance. Depending on the timing and outcome of CMS reviews, Iowa anticipates needing until September 30, 2023, to address any CMS feedback and remediate issues.

Additionally, on January 24, 2023, Iowa amended the CAP to CMS to complete validation of assessments results by specific settings and to complete heightened scrutiny review activities.

VI. Implementing Iowa's Statewide Transition Plan

This section described what Iowa did to identify all residential and nonresidential settings where HCBS are provided for the purpose of assessing compliance with the final rule. It also addresses how Iowa established and implemented a systematic process to review and assess the settings where members receive HCBS to determine if each setting complies with the final rule. For settings that did not initially comply, Iowa identified how each setting could comply and maintain compliance with the final rule. A process was established for the timely transition of members into settings that meet the HCBS settings requirements if there were settings that could not comply by the end of the transition period.

To accomplish these objectives, Iowa Medicaid took a multifaceted approach to discover, assess, evaluate, and remediate all residential and non-residential settings where HCBS waiver and Habilitation services are provided. As described previously, many processes existed prior to the implementation of the HCBS settings final rule and were leveraged, enhanced, or expanded to better inform the oversight of settings requirements. Where gaps existed, new processes and tools were created.

First, Iowa needed to identify all residential and nonresidential settings where HCBS are provided. Prior to the initial address collection project, Iowa generally did not track individual locations where HCBS was provided. There were some exceptions such as licensed environments like RCF and Assisted Living Facilities (ALF) that were tracked by their licensing entity, the Iowa Department of Inspections and Appeals (DIA) and individual, residential locations that had been approved by Iowa Medicaid to house five people. That first address collection process was therefore initiated to provide Iowa with a better idea of the number and location of all settings in the state. Initially, both member-owned or controlled and provider-owned or controlled residential locations where residential services of SCL, RBSCL, HBH, and "Other" services are provided, were collected to get a baseline understanding of where all HCBS settings are throughout the state. "Other" services included Assisted Living Service (which can only be provided in licensed ALF) and CDAC provided by an agency. Member-owned or controlled residential settings include homes of any type (house, apartment, mobile homes, townhomes, condominiums, etc.) that are owned or rented by the member and would be available to anyone within the community to rent or buy. It may also include settings where the member lives in a home of any type that is owned or rented by their family.

The first address collection process also collected all locations where non-residential services of adult day care, day habilitation, prevocational services, and supported employment were provided. No distinction was made as to whether any of these services were "individual" or "group based".

Geo-mapping technology was initially used to map all the provider-owned or controlled residential settings and all non-residential settings in Iowa that were collected through this initial address collection process and overlay them with known nursing facilities, IMD, ICF/ID, and hospitals. This helped ensure that HCBS was indeed not being provided in any settings deemed "not HCBS" and if it was, ensure the setting was included in the settings needing to be assessed for compliance. Geo-mapping also allowed some limited insight into the concentration of settings in certain areas and a very rudimentary understanding if any HCBS were provided on the campus of a public institution or within a publicly or privately operated facility that provides inpatient institutional treatment.

It was originally hoped that geo-mapping technology could be leveraged in a variety of ways, but it was essentially just used to map the data collected through the initial address collection process. The geo-map was revisited to see what information could be gleaned from it when the State began to categorize settings into heightened scrutiny categories, but it was ultimately not as useful as originally hoped. The

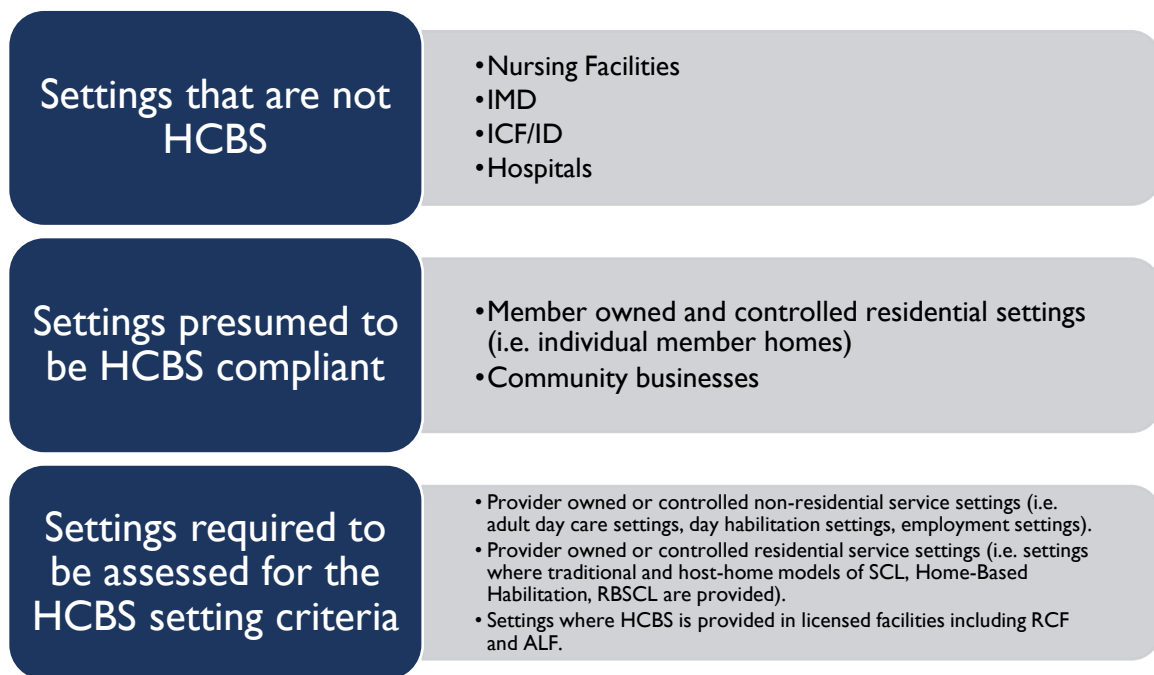
technology did not provide enough detail and could not be navigated interactively to allow the user to zoom in and out and explore certain areas.

Information from the address collection process as well as other known information about the State of Iowa provider network allowed Iowa to make some initial distinctions and separate them into:

- Settings that are not HCBS.
- Settings that are HCBS and presumed to be compliant with the final rule without any changes required.
- Settings required to be assessed for the HCBS setting criteria.

Below is a chart showing the types of settings that Iowa put into each of the distinctions outlined above.

Classifying Settings for Further Assessment



To organize an approach to both identification of settings and later for the assessment of settings, Iowa also broke HCB waiver and Habilitation services into services provided in residential settings and services provided in non-residential settings. The HCB Waiver and Habilitation Services chart below shows each HCB waiver and Habilitation service in Iowa and whether it was categorized as a service provided in a residential or non-residential setting and whether it was presumed to be HCBS compliant or required to be assessed for compliance. Services that by definition and scope of the service do not take place in a physical setting or do not have any control over the setting when the service is being provided there, have been left blank in the residential and non-residential columns. For example, counseling may be provided in a member's home, but the counseling service does not exercise any control over the member's environment for the short intervals they are there.

Some services may be provided in both provider-owned or controlled and member-owned or controlled residential settings. For example, the service of SCL may be provided on an intermittent or "15-minute" basis to a member living in their own home or the home of a family member. It may also be

provided as a “daily” service with the provider of the service owning or leasing the home and staffing the home, based on the needs of the members living there.

One model for delivering SCL and Home-Based Habilitation is referred to as a “host home” model. Host homes are not a defined service but a way of providing the existing services of SCL and Home-Based Habilitation. Any settings where a member lives with an unrelated caregiver in the caregiver’s home including these types of settings where SCL or Home-Based Habilitation services are delivered through a host home model are considered a provider-owned or controlled locations and are included under settings requiring assessment for compliance with HCBS settings criteria.

RBSCL is residential SCL for children. RBSCL can only be provided in provider owned or controlled homes. As previously identified, Assisted Living Service can only be provided in licensed ALF and therefore can only be provided in provider owned or controlled environments. There are many types of CDAC in Iowa, including CDAC provided by an agency. CDAC Agency may be provided in member owned and controlled homes or licensed facilities such as RCF or ALF. For the purposes of assessment for compliance with HCBS settings criteria, only settings where CDAC Agency services provided in licensed RCF or ALF were required to be assessed for compliance with HCBS settings criteria. All other settings where CDAC Agency is provided are member owned and controlled and would be presumed compliant with the final rule without any changes required and would be covered through general quality oversight. Iowa had originally identified Interim Medical Monitoring and Treatment (IMMT) and Mental Health Outreach (MHO) as services provided in a residential setting but later determined that by definition, the services are only provided in integrated, community-based settings or individual member homes and should not have been included. That change is reflected in the HCB Waiver and Habilitation Services by Setting Types chart below.

HCB Waiver and Habilitation Services by Setting Types

SERVICE	RESIDENTIAL	NON-RESIDENTIAL	PRESUMED TO BE HCBS COMPLIANT	REQUIRED TO BE ASSESSED FOR COMPLIANCE
Adaptive Devices			X	
Adult Day Care		X		X
Assistive Devices			X	
Assisted Living	X			X
Behavioral Programming			X	
Case Management Services			X	
Chore			X	
Financial Management Services for Consumer Choices Option			X	
CDAC	X		X-When provided in a member owned and controlled setting	X-When provided in provider owned or controlled setting
Counseling			X	
Day Habilitation		X		X

SERVICE	RESIDENTIAL	NON-RESIDENTIAL	PRESUMED TO BE HCBS COMPLIANT	REQUIRED TO BE ASSESSED FOR COMPLIANCE
Emergency Response			X	
Environmental Modifications			X	
Family and Community Support			X	
Family Counseling & Training			X	
Home-Based Habilitation	X		X-When provided in a member owned and controlled setting	X-When provided in provider owned or controlled setting
Home Delivered Meals			X	
Home Health Aide			X	
Homemaker			X	
Home/Vehicle Modifications			X	
In-home Family Therapy			X	
Interim Medical Monitoring & Treatment			X	
Mental Health Outreach			X	
Nursing			X	
Nutritional Counseling			X	
Prevocational Services		X	X-When provided one on one in a community business.	X-When provided as a group and/or in provider owned or controlled setting.
Respite			X	
Senior Companion			X	
Supported Community Living	X		X-When provided in a member owned and controlled setting	X-When provided in provider owned or controlled setting
Specialized Medical Equipment			X	
Residential-Based Supported	X			X

SERVICE	RESIDENTIAL	NON-RESIDENTIAL	PRESUMED TO BE HCBS COMPLIANT	REQUIRED TO BE ASSESSED FOR COMPLIANCE
Community Living (for children)				
Supported Employment		X	X-When provided to an individual in a community business/competitive employment setting.	X-When provided as a group and/or in provider owned or controlled setting.
Therapeutic Resources			X	
Transportation			X	

A. SETTINGS THAT ARE NOT HCBS

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

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

Iowa’s initial discovery process included identification of settings defined as “not HCBS”. Some Assisted Living Facilities where HCBS are provided were found to be physically attached to private nursing facilities. HCBS is provided in the ALF setting rather than the nursing facility setting but these settings were assessed for compliance with HCBS settings criteria because they are also considered provider owned or controlled residential service settings. This is explored more fully in the section about [heightened scrutiny](#) as these settings would also be categorized as Category I of heightened scrutiny: settings in the same building as a public or private institution.

B. SETTINGS THAT ARE HCBS AND PRESUMED COMPLIANT

There are settings where HCBS can be provided that are presumed to meet the HCBS settings rules without need for remediation. These settings, by their nature, are settings that are fully integrated into the community. Although these settings are presumed to be compliant with the final rule without a need for remediation, they are included in Iowa’s ongoing monitoring and quality oversight reviews.

In Iowa, these settings may include member owned and controlled residential settings where any HCB services are provided such as:

- Individual member’s homes of any type (houses, apartments, condominiums, etc.).
- Members living in their family home of any type.
- Integrated community rental properties available to anyone within the community.

Various services may be provided in member owned and controlled residential settings. However, Iowa specifically collected member owned and controlled locations where the HCB services of SCL, HBH, RBSCL, and “Other” services were provided through the initial address collection process. In subsequent years of the address collection process, data was not collected on member-owned or controlled locations.

These settings also include non-residential settings like:

- Individual prevocational services or supported employment service settings in community-based businesses.
- Individual day habilitation services in community-based settings.

In Iowa’s initial discovery process, there was no distinction made between individual non-residential service and any location where HCB non-residential services are provided. Instead, all locations where day habilitation, adult day care, prevocational, and supported employment services were provided were reported and assessed for compliance unless it was found to be provided in a community business such as individual, community-based supported employment service settings. Individual non-residential services provided in community businesses would be presumed to be HCBS compliant without a need for modification but because no initial distinction was made, some of these settings may have been included in Iowa’s initial assessment of settings. Additionally, individual non-residential services are included in Iowa’s ongoing monitoring and quality oversight processes.

Beginning in 2022, the address collection process was updated to collect all provider owned or controlled day habilitation, adult day care, prevocational, and supported employment service settings. From there, the tool allows the reporter to select more specific details such as whether the setting is a 100% community based or “no walls” day habilitation service setting, a site based prevocational service setting such as a sheltered workshop, or group/enclave supported employment program.

All settings that have been classified as “presumed to be HCBS compliant”, continue to be subject to quality oversight review which includes settings compliance and the annual SA where the provider answers for all settings where they provide the identified services. Members selected for quality oversight Periodic or Certification Review and applicable Focused Reviews could be receiving any number or combination of services the provider is enrolled to provide and could be receiving them in any type of setting. This ensures that all settings where they receive services are evaluated for compliance with settings requirements. Additionally, all members receive a Residential Assessment at least annually. The Residential Assessment includes evaluation of whether the member’s residential setting meets some basic settings requirements even if the member lives in a member owned and controlled setting.

C. SETTINGS REQUIRED TO BE ASSESSED FOR COMPLIANCE

The remaining settings were required to be assessed for HCBS settings criteria to determine if they could comply with final rule with or without modifications or if the setting would be unable to comply.

These settings included:

- Provider owned or controlled non-residential service settings (i.e. adult day care settings, day habilitation settings, employment settings).

- Provider owned or controlled residential service settings (i.e. settings where traditional and host-home models of SCL, Home-Based Habilitation, RBSCCL are provided).
- Settings where HCBS is provided in licensed facilities including RCF and ALF.

As is explored more fully in subsequent sections, Iowa took two paths to assess these groups. Non-residential service settings were primarily assessed through the special Focused Review project and residential service settings were assessed through the Residential Assessment process. Additionally, we might assess individual settings through a quality oversight review or ad hoc settings assessment.

Provider owned or controlled settings where prevocational service and supported employment services are provided were determined as needing to be assessed for compliance with HCBS settings criteria. This includes group or enclave employment settings where members are clustered or grouped together for the purpose of receiving HCBS. As explained previously in this section, there was originally no distinction made in reporting employment settings as either provider owned or controlled or individual employment services. Beginning in 2022, the address collection process was updated to collect all provider owned or controlled prevocational and supported employment service settings and the ability was added to distinguish which employment settings were “site-based” or group/enclave based.

Provider owned or controlled settings where adult day care and day habilitation services are provided were also determined as needing to be assessed for compliance with HCBS settings criteria. This would include day habilitation services provided as 100% community-based or “no walls” service models since members would still be grouped together for the purpose of receiving HCBS. Again, beginning in 2022, the address collection process was updated to distinguish between site based and 100% community-based day services as described previously in this section.

Throughout the transition period, some providers of day habilitation services developed 100% community-based or “no walls” day habilitation program models where members meet in the community and access the community throughout the entire service. Due to the definition and nature of the licensure requirements for adult day care, this service is always provided to groups with a main center or site. Prior to the PHE, some providers of day habilitation services implemented programs that were entirely “no walls” while others offered this type of day service in addition to center-based activities. When day habilitation is delivered in this manner, there is no centralized location or specific site where the services take place but because members are grouped together for the purpose of receiving HCBS, this model of day habilitation service delivery still requires assessment. As the PHE winds down, it is believed that there has been a return to the non-site-based service delivery model.

Day habilitation services may be provided on an individual basis, especially for individuals who may have difficulty in groups. Adult day care and day habilitation programs were required to be closed in mid-2020 during the height of the PHE and throughout the PHE, providers were allowed the flexibility of providing day habilitation services to members in their own homes which resulted in more individual day habilitation services. Since adult day care centers and day habilitation centers have returned to normal operations, individual day habilitation services are likely to have returned to use only for members needing that level of service. However, the number of members using individual or individual day habilitation services has not been tracked to validate this assumption. Individual day habilitation services are included in ongoing non-residential settings monitoring. The monitoring will assure that the community-based services where individual day habilitation services are provided are the same type of settings and offer the same type of experiences as those used and experienced by the local community.

There are two HCB “residential” services that might be provided in an RCF or ALF setting. They are Assisted Living Service and CDAC Agency. CDAC can be provided in a variety of ways in Iowa. Only settings where CDAC is provided by an agency in an RCF or ALF are included here. Until the 2022 address collection process, these two services were collectively referred to as “other” services. Assisted Living Service can only be provided by licensed ALF. Therefore, both Assisted Living Service and CDAC as described here are only provided in provider owned or controlled settings which require assessment for compliance with HCBS settings criteria.

D. ASSESSING SETTINGS

In order to assess the settings identified above, Iowa Medicaid used their existing processes and enhanced, expanded, or created new processes and tools where gaps existed.

These processes include:

- Provider quality self-assessment, address collection, and attestation (form #470-4547)
- Quality oversight and review and specifically the SFY17-18 and SFY23 Focused Reviews
- Residential Assessments
- Settings Assessments

I. ASSESSMENT THROUGH THE PROVIDER QUALITY SELF-ASSESSMENT, ADDRESS COLLECTION, AND ATTESTATION

The Provider Quality Self-Assessment tool, including the attestation portion, have been used since the early 2000’s to enhance the regular, ongoing review of providers of HCBS in Iowa. With the introduction of the HCBS settings requirements in 2014, subsequent, Provider Quality Self-Assessments were updated to include criteria related to HCBS settings requirements. It continues to be used as a tool for ensuring settings remain compliant.

The SA includes questions about policies, procedures, and systems the provider has in place for meeting settings requirements in all environments where they provide the identified HCBS waiver and Habilitation services. Providers indicating “No” to meeting a standard must also provide a Corrective Action Plan (CAP), implementable within thirty days, outlining how they will come into compliance with the standard. The provider’s QIO HCBS Specialist reviews each submission for completeness and accuracy. Discrepancies and inadequate CAP are resolved prior to acceptance of the provider’s annual SA. Successful implementation of identified CAP are reviewed with the next annual self-assessment or through a regular review process, whichever comes first. Every provider has self-assessed for compliance with setting criteria in all locations where they provide HCBS up to eight times.

The Address Collection Tool ([Attachment E](#)) was a new process created in response to the implementation of the final rule. The Address Collection Tool is required to be completed as part of the annual self-assessment and requires providers to list the locations where they provide SCL, RBSCL, HBH, Assisted Living Service, and CDAC Agency in an RCF or ALF, prevocational services, supported employment, day habilitation and adult day care. Originally, all locations where these services are provided was collected.

For residential settings, the provider listed the address of the setting, checked which residential services were provided in the setting, and selected the type of residence such as “apartment”, “house”, or “duplex”. Additionally, the provider selected yes or no as to whether it was licensed environment or

had a five-person home approval from Iowa Medicaid. The tool was enhanced over the years to refine the data that is collected and to ensure more consistent entry and reporting. Starting with the 2022 address collection process, provider training on the completion of the tool emphasized the need to enter just provider owned or controlled residential settings where the above-named services are provided. Providers were instructed to include SCL done as a “host home” model as a provider owned or controlled location. The selections for the type of residence were updated and put into a drop-down so that providers are not able to enter anything other than the available options. The available options were updated to include any unit in a multi-plex (apartment, duplex, condominium), any type of house (house, townhouse, trailer), DIA licensed RCF or ALF, or host home. The DIA licensure type and five-person approvals were separated into separated columns and the DIA license types were put into a drop down to select from the level of licensing.

For non-residential service settings, the address collection tool also evolved and now includes a drop-down to select the type of non-residential setting from these available options: settings where site-based prevocational services are provided, settings where group, site-based supported employment services are provided, settings where site-based adult day care and day habilitation services are provided, and identification of 100% community-based "no walls" day habilitation programs.

Although the address collection tool and data itself does not work to “assess” the settings, it does require providers to self-identify all the settings where they provide certain services and ensure they are attesting to compliance in all the identified settings when they sign the attestation portion of the self-assessment. It also helps with ongoing discovery of settings.

2. ASSESSMENT THROUGH QUALITY OVERSIGHT REVIEW

The QIO HCBS Unit’s quality oversight Periodic or Certification Review checklists were updated to match the self-assessment shortly after the introduction of the HCBS settings requirements in 2014. Therefore, all Periodic or Certification Reviews completed since then included assessment for compliance with settings criteria. Every provider subject to HCBS quality oversight is selected for a Periodic or Certification Review at least once per five-year cycle or according to their certification end date. Consequently, every provider has been assessed by the QIO HCBS Unit through a Periodic or Certification Review process at least once.

Beginning in July 2022, the regular Periodic and Certification Review processes includes tours of a random selection of non-residential and provider owned or controlled residential locations based on what services the provider is enrolled to provide and what types of locations the provider operates. During the tour, the HCBS Specialist assesses the location for compliance with HCBS settings criteria and compares those findings with other evidence included in the review.

The Focused Review topic changes annually based on historical data, trends with providers and Iowa Medicaid’s needs. The Focused Review topic in SFY17 and SFY18 was focused on assessing HCBS setting readiness and compliance in non-residential settings. All providers enrolled for prevocational services, supported employment, day habilitation, and adult day care services at the time, were selected for a Focused Review in those years. These Focused Reviews included tours and assessment of each site where these services occurred as well as overall review of the provider’s policies, procedures and a representative selection of staff and member records. Every setting where HCBS prevocational services, supported employment, day habilitation, and adult day care services was provided have been assessed for compliance with settings requirements.

In SFY23, the Focused Review topic is HCBS settings compliance in residential settings including verification of responses on selected member's most recent Residential Assessment.

3. ASSESSMENT THROUGH THE RESIDENTIAL ASSESSMENT TOOL

The HCBS Residential Setting Member Assessment ([Attachment C](#)) was created as a means of assessing individual member's homes for compliance with HCBS settings requirements. The tool is to be administered at least annually by the member's case manager. Since every HCBS waiver and Habilitation member receives a Residential Assessment, every residential setting where HCBS waiver and Habilitation services are provided is evaluated for compliance with settings requirements. Non-compliance with HCBS settings criteria is captured through the "flagged" question process whereby the QIO HCBS Unit is notified, follows up with the member's case manager and initiates a process of remediation as applicable. Depending on the issue, a flagged response may also lead to follow-up with an involved provider to participate in the remediation process for the individual member.

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

The Residential Assessment tool is in the process of being updated to allow for better data collection and validation of results and to ensure all standards of HCBS settings are explicitly included in the "guidance questions". For example, on the current Residential Assessment, the cell for entering the addresses is free text allowing the information to be entered with extra spaces, misspellings, and with inconsistencies such as "St" versus "Street" and "1st" versus "First". It cannot be compared to other data, such as the address collection process, to validate that all residential locations where the services are provided have been assessed. However, data can be provided to show the total number of Residential Assessments that have been completed since its implementation as compared to the number of enrollees in Iowa Medicaid's HCBS waiver and Habilitation services for the same time period to demonstrate that every member, and therefore every residence, has been assessed at least once with the Residential Assessment.

4. SETTINGS-SPECIFIC ASSESSMENT

Although quality oversight reviews and Residential Assessments are the main mechanisms for assessing settings for compliance, the Settings Assessment Tool ([Attachment F](#)) was created as a means of consistently assessing and documenting the assessment of settings that are reviewed outside of a regular Periodic, Certification or applicable Focused Review. It is a tool rather than a process, but it should be mentioned here because it is a tool used to guide the assessment of a specific site and can contribute to an overall quality oversight process and findings. The tool includes a checklist of standards pulled from the settings sections of the SA and corresponding sections from the quality oversight review checklists. An HCBS Specialist might use this tool to evaluate a new setting that requires assessment or as a guide to evaluate a setting with a settings-related incident or complaint or in a variety of other circumstances.

Findings from a Settings Assessment can be compared to the most recent SA and quality oversight review for the provider operating the setting. Settings Assessments completed outside of a regular quality oversight review may be used as a piece of evidence in any future quality oversight reviews with the provider operating the setting.

D. REMEDIATION OF NON-COMPLIANT SETTINGS

When a setting was found through one of these assessment methods to require modification or follow-up, a remediation process specific to the type of assessment activity was followed.

Non-compliance found through the annual Provider Quality Self-Assessment follows the SA CAP processes explained [here](#). Providers indicating “No” to meeting a standard must also provide a written CAP directly into the SA document. The CAP must be implemented within thirty days, Inadequate CAP are resolved prior to acceptance of the provider’s annual SA. Successful implementation of identified CAP are reviewed with the next annual self-assessment or through a regular review process, whichever comes first.

Non-compliance found through a regular quality oversight review process (i.e. Periodic, Certification, Focused or Targeted Review), including the special Focused Review project of SFY17-18, follows the CAP and compliance follow-up processes identified [here](#). Providers are given thirty days from the receipt of the report outlining the CAP requirements to respond with their plan for remediating the issue and coming into compliance. Once a CAP is accepted, the provider has sixty days to carry it out before the QIO HCBS Unit initiates a follow-up compliance review. The compliance review will include review of any evidence necessary to ensure the CAP was successfully carried out and to demonstrate that the provider now complies with the criteria.

Non-compliance found through a Residential Assessment is captured through the “flagged” question process whereby the QIO HCBS Unit is notified of a flag, follows up with the member’s case manager and initiates a process of remediation as applicable. Depending on the issue, a flagged response may also lead to follow-up with an involved provider to participate in the remediation process for the individual member. See [here](#) for a full description of the remediation process that occurs when non-compliance is found through a Residential Assessment.

Non-compliance found through a Settings Assessment may be handled through immediate recommendations for remediation or by referring to a regular quality oversight review such as a Targeted Review. From there, the CAP and compliance processes identified [here](#) are followed.

E. ASSESSMENT RESULTS

Through assessment of the above identified settings, it was determined that some settings were compliant without any need for remediation and some settings required remediation. Others were found to be potentially unable or unwilling to comply.

Settings that Complied with or without Modifications

Some settings were found to be compliant with HCBS settings criteria without a need for modifications meaning that a quality oversight review did not reveal any areas of non-compliance in any of the provider’s settings. Quality oversight review outcome reports can show how many providers have had a quality oversight review with corrective action related to HCBS settings.

Some settings could comply with the HCBS settings rule with some modification to the provider’s operation of the setting or services provided in the setting. Providers that have identified compliance

issues developed a CAP to explain how the provider would come into compliance. A CAP may require changes at the organizational level (i.e., policy and procedures) or changes at the individual member level such as changes to the member's person-centered plan.

Settings that were Unable or Unwilling to Comply

Some settings were found to be potentially unwilling or unable to comply but all of the providers operating those settings ultimately discontinued providing services in the non-compliant setting and may have voluntarily disenrolled from the service before a final determination was made. Some providers may have cited the discontinuation of services or disenrollment from a service as their remediation plan. Specifically, since the implementation of the final rule, several providers of prevocational services in "sheltered workshops" stopped providing HCBS funded prevocational services in the workshop setting and members were transitioned to other settings or services before a final determination was made. No providers of any services are currently deemed "unable or unwilling to comply".

F. TRANSITION PROCESS FROM NON-COMPLIANT SETTINGS

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

Iowa established an internal deadline of November 30, 2022 for providers to fully remediate issues and demonstrate compliance. The deadline was preceded by a series of notifications, sent every thirty days, alerting these providers that they have what may be a shortened timeline to return an acceptable plan of remediation (CAP) or to fully implement an already approved remediation plan and therefore achieve compliance by Iowa's final compliance deadline of November 30, 2022. By the time the notification process was implemented in September 2022, only 7 residential settings (5 providers) and 3 non-residential settings (3 providers) had not achieved compliance and received the notification letters. The final compliance deadline of November 30, 2022 allowed Iowa Medicaid members receiving services in a setting that is unable or unwilling to achieve compliance more than three months to transition to a compliant setting or make alternative plans.

If a provider exhausted their opportunities and timeline to remediate issues and received notification of the intent to transition members from that setting, the QIO HCBS Unit would notify the affected members and their case managers of the need and timeline to transition the members from the setting. This notification would be sent approximately ninety days in advance of the deadline for transition. Notices would be mailed to members or their legal representatives while at the same time, the members' case managers are notified via email. Case managers are responsible to actively facilitate the transition of care and provide weekly status reports to the members' MCO and the QIO HCBS Unit.

Case managers have a responsibility to carry out a person-centered planning process which includes ensuring members have the opportunity, information, and supports to make informed choices of an alternative setting. Case managers and MCO, as applicable, must monitor all aspects of the transition process for their assigned members and address any issues that may arise and ensure that there is a seamless transition of care. The State ensures critical services and supports are in place in advance of each transition through regular communication with the member's case manager and MCO and by

providing ample advanced notice of a need to transition. Members will not transition prior to a suitable alternative being in place.

As of December 30, 2022, there are no settings identified as unable or unwilling to comply that did not already transition members from the setting. However, Iowa did submit a Corrective Action Plan (CAP) to CMS on December 1, 2022 outlining a plan and timeline for ensuring all settings are compliant should the results of a CMS heightened scrutiny review determine that Iowa does still have settings requiring further remediation or settings that are unable to comply.

G. HEIGHTENED SCRUTINY REVIEW AND REFERRAL

Iowa's discovery and assessment processes also worked to identify settings that meet a category of heightened scrutiny as defined in the Federal regulation because the setting is presumed to have the qualities of an institution or otherwise isolates individuals receiving HCBS from the broader community. CMS established three categories of settings that require heightened scrutiny.

- **Category 1:** Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- **Category 2:** Settings in a building on the grounds of, or immediately adjacent to, a public institution; or
- **Category 3:** Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

I. INITIAL IDENTIFICATION OF SETTINGS REQUIRING HEIGHTENED SCRUTINY

Category I

Iowa concludes that 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/ID, and IMD). Iowa found that some ALF where HCBS are provided are physically attached to nursing facilities, but HCBS is provided in the ALF setting rather than the nursing facility setting. All providers operating ALF settings that are attached to a nursing home received at least one Periodic Review including an assessment of the setting. Additionally, all members living in an ALF attached to a nursing home have also received a Residential Assessment assessing their individual living environment.

Iowa had previously understood that CMS heightened scrutiny review was not required for settings that meet any category of heightened scrutiny if the provider operating that setting submitted a CAP to address compliance issues and fully implemented required changes before July 1, 2021. In February 2023, CMS provided feedback to Iowa, explaining that the guidance only applied to settings meeting Category 3 of heightened scrutiny. Settings meeting categories 1 or 2 are required to be submitted for CMS heightened scrutiny review even if the State has determined through the State's assessment processes that the setting has overcome the institutional presumption before July 1, 2021.

Iowa must therefore submit all settings for heightened scrutiny that meet Category I. This project will begin in March 2023 and it is anticipated that these settings will be submitted for a public comment starting May 1, 2023. After the designated period of public comment, the comments will be summarized and a package of evidence summary to include responses to public comments will be referred to CMS.

Iowa amended the Corrective Action Plan (CAP) to CMS to incorporate these additional heightened scrutiny reviews.

It is noted that Iowa identified one setting as an IMD providing the HCB services of SCL and day habilitation. The provider operating the setting immediately ended HCBS in the setting.

Category 2

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

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

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

Iowa concluded that the only “public institutions” in the state are 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. Iowa found through comparison of street addresses and the previously described geo-map, that no HCB services were provided in a building on the grounds of, or immediately adjacent to, these public institutions.

Category 3

To initially identify settings that may have the effect of isolating individuals receiving Medicaid HCBS from the broader community, the State used the geo-map to look for “clusters” of settings. From there, Iowa relied on assessment results from quality oversight Periodic, Certification, and applicable Focused Reviews as well as Residential Assessments to identify settings that met Category 3 of heightened scrutiny. Only Residential Assessment flags that led to the need to involve the provider operating the setting in the remediation would be moved forward for heightened scrutiny review. All other matters are remediated within ten days at the individual member level between the member and the member’s case manager.

It is noted that earlier versions of Iowa’s STP identified twelve providers operating settings that met Category 3 of heightened scrutiny as of June 30, 2019. However, per CMS guidance, providers that submit a CAP to address compliance issues and fully implement required changes before July 1, 2021, were not required to be put forward for heightened scrutiny review by CMS. All twelve of the identified providers remediated issues prior to July 1, 2021. These twelve providers were operating a variety of settings as outlined below.

1. Mediapolis was providing the service day habilitation in their licensed RCF.
2. Tenco was providing prevocational services in a sheltered workshop type of setting.
3. Ragtime Industries was providing prevocational services in a sheltered workshop type of setting.

4. Senior Suites of Urbandale was a licensed ALF providing Assisted Living Service and/or CDAC Agency services.
5. One Vision was operating provider owned or controlled residential settings where the services of SCL or Home-Based Habilitation were provided.
6. Park Place Agency was a 15-bed licensed RCF providing Home-Based Habilitation services.
7. Mosaic was operating provider owned or controlled residential settings where SCL or Home-Based Habilitation were provided.
8. Hills and Dales was operating provider owned or controlled residential settings where SCL was provided.
9. Eyerly Ball was providing the service day habilitation in their licensed RCF.
10. Community Adult Residential Environment (CARE) was a licensed RCF where SCL or Home-Based Habilitation were provided.
11. Circle of Life was operating provider owned or controlled residential settings where SCL was provided.
12. Evergreen Estates (I, II, and III) were RCF providing CDAC Agency.

However, some providers were found to be operating settings that met Category 3 of heightened scrutiny after the July 1, 2021 deadline or were found to be out of compliance after having previously met compliance and the area of non-compliance was related to or caused the setting to fall into a category of heightened scrutiny. Those providers will be moved forward for heightened scrutiny review by CMS to ensure CMS's final approval by March 17, 2023.

2. ONGOING IDENTIFICATION OF SETTINGS REQUIRING HEIGHTENED SCRUTINY

After March 17, 2023, any setting determined to need CMS heightened scrutiny review and approval will need to receive this before receiving HCBS funding in the setting. Providers will be required to submit new HCBS settings to the QIO HCBS Unit. A tool is in development to screen new settings and determine if the setting requires assessment including heightened scrutiny review. The screening tool will include questions directly related to heightened scrutiny criteria (i.e. Is this setting located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment?).

Additionally, Iowa's quality oversight processes are ongoing and cyclical which lends well to ongoing identification, review, and remediation of HCBS settings standards including settings that require heightened scrutiny review. Settings are identified through regular Periodic or Certification Review, applicable Focused Reviews, annual self-assessment and address collection processes, Residential Assessment flags, application review, or notifications and referrals from any source such as member or other stakeholder complaints. Although settings assessment is not the singular purpose of any of these processes or tools, each may include some element of screening to determine if a settings meets a category of heightened scrutiny. For example, the Residential Assessment tool asks questions that might identify a setting as isolating which would be referred to the QIO HCBS Unit for follow-up.

Iowa will employ one of the assessment or quality oversight review processes in the following circumstances.

- A new provider applies for an HCBS waiver or Habilitation service and plans to operate a setting that potentially requires assessment for compliance with HCBS settings criteria or potentially meets a category of heightened scrutiny. This includes new, presumptively institutional settings such as newly established, licensed facilities.
- An existing provider applies for an HCBS waiver or Habilitation service and plans to operate a setting that potentially requires assessment for compliance with HCBS settings criteria or potentially meets a category of heightened scrutiny. This includes new, presumptively institutional settings such as newly established, licensed facilities.
- An existing institutional residential care settings converts to HCBS waiver or Habilitation service provision (e.g., ICF/ID or non-HCBS RCF convert to HCBS waiver or Habilitation services)
- An existing provider of applicable HCBS waiver and Habilitation services previously found in compliance are reviewed through quality assurance activities and found to be out of compliance and the area of non-compliance is related to or caused the setting to fall into a category of heightened scrutiny.

When a new provider applies for an HCBS waiver or Habilitation services subject to quality oversight, the application is reviewed by the QIO HCBS Unit. The application review process assures a new provider is compliant with the setting requirements prior to enrollment as a HCBS waiver or Habilitation service provider with Iowa Medicaid. A new provider may not bill for services until they are enrolled with Iowa Medicaid. New providers are required to complete the Provider Quality Self-Assessment and receive QIO HCBS Unit approval prior to service provision. The Provider Self-Assessment will identify service settings where any residential and non-residential services will be provided. Any new setting identified as meeting criteria in categories 1, 2 or 3, will require QIO HCBS Unit approval prior to HCBS service provision and payment for services in the setting and may require a heightened scrutiny review and CMS approval.

When an existing provider applies for an HCBS waiver or Habilitation services subject to quality oversight, the application is also reviewed by the QIO HCBS Unit in the same manner as for a new provider. Iowa Medicaid has established a process to capture new, presumptively institutional settings such as newly established, licensed facilities and conversions of facilities to HCBS waiver or Habilitation services through collaboration with the licensing entity, DIA. Additionally, Iowa Medicaid is developing an Informational Letter to inform all providers of the need to notify Iowa Medicaid when establishing a new location that requires assessment for compliance with HCBS settings requirements and potentially a heightened scrutiny review and approval from CMS.

Providers operating settings that were initially found to comply with HCBS settings criteria prior to March 17, 2023 but are found to be out of compliance through a subsequent quality oversight review may not be required to be put forward for heightened scrutiny review if the area of non-compliance does not relate to or cause the setting to fall into a category of heightened scrutiny.

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

Iowa's heightened scrutiny review will evaluate whether the setting overcomes the institutional presumption and the effect of isolating Medicaid HCBS members from the broader the community through:

- Review of policies and procedures to ensure they are aligned with HCBS settings requirements.
- Review of staff training to ensure staff providing HCBS are trained to effectively implement the HCBS settings requirements.
- Evaluation of the physical setting.
- Review of member's experience in the setting.

Outcomes of Iowa's heightened scrutiny review may include any combination of the following:

- A determination that the setting overcomes the institutional presumption and the effect of isolating.
- A determination that the setting could overcome the institutional presumption and the effect of isolating with remediation. The QIO HCBS Specialist must follow up with the provider to implement remediation plans before approving the setting.
- A determination that the setting cannot meet requirements for HCBS settings with or without remediation.

A summary of Iowa's heightened scrutiny findings will be posted for public comment on the HHS website for thirty days after which the public comments, responses, and summary of findings are referred to CMS for final heightened scrutiny review and approval.

3. REFERRALS FOR CMS HEIGHTENED SCRUTINY REVIEW

When a setting is determined to require heightened scrutiny review and approval by CMS, findings from assessment and quality oversight review activities are summarized and documented by the assigned HCBS Specialist in a Package of Evidence Summary document ([Attachment G](#)). The Package of Evidence Summary will be reviewed and approved by the Iowa Medicaid STP Workgroup before posting to the designated Iowa Medicaid [webpage](#) for a thirty-day public comment period. When published for public comment, Iowa Medicaid will send notice to the CMS STP transition team identifying the date and provider name that have been posted to the website.

At the conclusion of the public comment period, Iowa Medicaid will evaluate and summarize the public comments received and all comments will be sent to CMS along with a list of the settings designating the setting type and the heightened scrutiny category. A sample will be selected by CMS. CMS will notify the State of their selections. The Package of Evidence Summary is then finalized and sent to CMS for review along with any other supporting documentation required or requested by CMS.

All settings that meet Category 3 of heightened scrutiny and had not fully implemented required changes before July 1, 2021, have been posted for a thirty-day public comment period. The comments and a list of the settings will be sent to CMS for selection at the end of the public comment period.

Iowa had previously understood that CMS heightened scrutiny review was not required for settings that meet any category of heightened scrutiny if the provider operating that setting submitted a CAP to address compliance issues and fully implemented required changes before July 1, 2021. In February 2023, CMS provided feedback to Iowa, explaining that the guidance only applied to settings meeting Category

3 of heightened scrutiny. Settings meeting categories 1 or 2 are required to be submitted for CMS heightened scrutiny review even if the State has determined through the State's assessment processes that the setting has overcome the institutional presumption before July 1, 2021.

Iowa must therefore submit all settings for heightened scrutiny that meet Category 1. This project will begin in March 2023 and it is anticipated that these settings will be submitted for a public comment starting May 1, 2023. After the designated period of public comment, the comments will be summarized and a package of evidence summary to include responses to public comments will be referred to CMS. Iowa amended the Corrective Action Plan (CAP) to CMS to incorporate these additional heightened scrutiny reviews. At this time, there are also two additional providers in review by the QIO HCBS Unit that will be sent for public comment and heightened scrutiny review at the conclusion of the review process. Both providers are operating newly established RCF and wish to provide HCBS waiver or Habilitation services in the settings.

VII. Validation of Results

Previous versions of Iowa's STP provided point-in-time information about Iowa's progress in implementing the approved STP. Some of the charts were not compatible with standards under Section 508 of the Rehabilitation Act and some data cannot be updated with currently available data, particularly as it related to compliance results in each residential service setting. Iowa has consulted with CMS regarding the available data and discussed potential ways data could be tracked to fully demonstrate the results of Iowa's initial assessment of settings. While all settings requiring assessment have been assessed either through the non-residential Focused Review project of SFY17-18 or through completion of a Residential Assessment, Iowa has been unable to validate the results of those assessments due to how the data was collected. CMS has requested validation of the total number of settings in the state requiring assessment, how many were assessed, and whether the setting complied with modifications, without modifications, or if the setting was found to be unwilling or unable to comply. If the setting was found to be unwilling or unable to comply, Iowa should show how many settings disenrolled from services or discontinued providing services in the setting as a result. Iowa is working to allow reporting of validation results to be displayed in a chart like the example in [Attachment I](#).

Iowa has already made changes to key processes so that data collected going forward will be tracked at this level but as discussed with CMS, the results of these changes will not be available for collection and analysis for several months. To produce the necessary historical data, manual data collection and research will be required and is also estimated to take several months to produce.

On January 24, 2023, Iowa submitted a CAP to CMS to complete validation of assessments results by specific settings and to complete heightened scrutiny reviews.

A. RESULTS FROM AVAILABLE DATA

Using data that is currently available, this section outlines results from Iowa's assessment of both residential and non-residential settings requiring assessment for compliance with HCBS settings requirements and validates to the extent possible, that these settings have been assessed and remediated appropriately when applicable.

All Settings

First, every provider of HCB waiver and Habilitation services has attested to compliance with HCBS settings requirements in every setting where they provide the identified HCB services since the settings

requirements were added to the self-assessment tool in 2014. That means providers have assessed themselves for compliance up to eight times.

Between August 1, 2014, when settings requirements were first added to quality oversight review checklists, and June 30, 2022 there have been 865 quality oversight Periodic or Certification Reviews initiated which included review of the provider’s compliance with HCBS settings requirements and validation of responses of the provider’s last SA. There are currently 451 providers which shows that every provider of HCB waiver and Habilitation services has received at least one quality oversight review that included assessment for compliance with settings criteria. Between August 1, 2014 and June 30, 2022, 157 of those reviews included corrective action related to HCBS settings requirements. Some of the reviews with corrective action were still open as of June 30, 2022 meaning they have not achieved full compliance with all standards included in the review process. However, all areas of non-compliance related to HCBS settings requirements were fully remediated prior to November 30, 2022 which was Iowa’s internal deadline for compliance.

CMS previously asked how many settings that were unable or unwilling to comply have discontinued HCBS or disenrolled. The number of enrolled providers and the services for which the providers are enrolled changes as new providers are added or as existing providers enroll for addition services or as providers disenroll from services. The chart below titled Number of Providers Disenrolled by Service, shows the number of providers that have disenrolled by each service since 2014 when the HCBS final rule was implemented, and Iowa’s providers first became aware of the associated requirements. Iowa does not track the reason for disenrollment for providers so some of these providers disenrolled for reasons other than inability or unwillingness to comply with HCBS settings rules. The chart shows disenrollment for the entire service. Iowa does not enroll by service setting but rather each provider enrolls for the desired services and may provide them in any settings as appropriate to the definition and scope of the service. A provider may disenroll from a single service or disenroll entirely. The chart does not account for providers who discontinued services in a certain setting but remained enrolled for the service (i.e., closed one center where day habilitation services are provided but did not disenroll from the day habilitation service and may continue providing it in another location).

Number of Providers Disenrolled by Service

Services	Number of Providers
Adult Day Care	13
Day Habilitation	30
Prevocational Services	13
Supported Employment- all	18
Supported Community Living or Home-Based Habilitation – all	66
CDAC Agency- provided in an RCF or ALF	28
Assisted Living Service	24

Source: SQL Report: ProvidersTerminatedforHCBServices

Number of providers who disenrolled from one or more of the identified services between July 1, 2014 and December 31, 2022.

Non-Residential Settings

All non-residential settings were assessed and validation of the point-in-time results of the assessments is demonstrated in STP [Version 1.5](#) starting on page 27 and summarized below based on feedback from CMS.

The Focused Review project that assessed all locations where the non-residential services of adult day care, day habilitation, prevocational services, and supported employment services began in February 2017 just after the 2016 self-assessment process concluded. According to the 2016 Provider Quality Self-Assessment data there were a total of 111 providers of one or more of those non-residential services operating a reported 235 non-residential service locations. During the project, 105 Focused Reviews were initiated. Other providers received a Focused Review combined with a Periodic or Certification Review if they were due for one during the time frame. As part of the project, every location where one or more of the non-residential services was provided was toured and assessed for compliance with HCBS settings criteria.

Although only 235 non-residential locations were reported through the 2016 address collection process, 322 different settings were identified in STP Version 1.5 as assessed through the SFY17-18 Focused Review project. This is likely due to the fact that more than one service can be provided at a location, but the services were assessed as separate settings during the assessment process. For example, adult day care and day habilitation may be provided in the same building or location, but they were assessed as separate settings. It is also likely that additional locations were added between the 2016 address collection reporting period and the conclusion of the Focused Review project in late 2019. Per Iowa's corrective action plan, the data below will be verified using the 2022 address collection data and completed assessment results.

Below is a chart that partially demonstrates assessment results of non-residential settings based on information Iowa has at this time. The data is from STP Version 1.5 and demonstrates outcomes at a point in time based on the SFY17-18 special Focused Review project. The available data does not allow for complete reporting of the total number of non-residential settings by service type (adult day care, day habilitation, prevocational services, and supported employment). Additional settings may have been assessed since this point in time and must be counted and added to the number of settings assessed. Assessment outcomes including "complied with modifications" or "complied without modification" need to be verified as results cannot be reproduced with available data.

A few non-residential service providers were identified as potentially being unwilling or unable to comply with HCBS settings requirements but voluntarily stopped providing HCBS funded services in the non-compliant setting or disenrolled from non-residential services. Specifically, since the implementation of the final rule, several providers of prevocational services in "sheltered workshops" stopped providing HCBS funded prevocational services in the workshop setting. Per the STP [Version 1.5](#) on page 32, forty-one providers had disenrolled between the 2014 introduction of the final rule and December 2019. Since then, the reason for a provider ending services in specific setting or disenrollment reasons are not tracked. However, any provider operating a setting that cannot comply with the HCBS settings requirements has voluntarily ended services in the setting and members have already been transitioned to other settings. No providers of any services are currently deemed "unable or unwilling to comply".

Iowa has submitted a CAP to CMS to complete the validation of assessment results. Through the CAP, Iowa will ensure accurate reporting of the total number of settings by service type, the total number of settings assessed, and the outcome of the assessment. Additionally, Iowa hopes to validate the total number of settings that were unable or unwilling to comply and discontinued services in the non-compliant setting as a result.

Results of Non-Residential Settings Assessments

Assessment Results	Adult Day Care	Day Habilitation	Prevocational Services	Supported Employment
Number of Settings of Assessed	26	155	69	72
Complied Without Modifications*	19	147	62	72
Complied With Modifications	7	8	7	0
Unwilling or Unable to Comply*	0	0	Unknown	0

Source: 2016 Self-Assessment Data and CAP Details Reports for Non-Residential Service Settings Focused Reviews and Combined Periodic/Certification Reviews and STP Version 1.5

Number of each non-residential service settings by service type that were assessed for compliance with HCBS setting criteria between February 2017 and October 2019 and outcomes of the assessment.

Two providers operating Prevocational Service settings were determined to meet Category 3 of heightened scrutiny and will be put forward for CMS heightened scrutiny review. They were found to be out of compliance in a subsequent quality oversight review after the initially being found compliant in the non-residential settings Focused Review project of SFY17-18 and the area of non-compliance relates to or caused the setting to fall into a category of heightened scrutiny.

Residential Settings

Residential service settings were assessed mainly through the Residential Assessment process but compliance in residential settings is also a component of all Periodic or Certification Reviews and all self-assessments. As noted previously, the topic of the current SFY Focused Review is settings compliance in residential service settings including validation of Residential Assessment responses.

The Residential Assessment process started in December 2017. Between December 2017 and December 2022, more than 125,580 Residential Assessments have been completed meaning that 125,580 residences have been assessed. Of the total number of Residential Assessments completed, 30,844 were assessments of provider owned or controlled residential settings. At any given time in the last five years, Iowa has around 30,000 to 32,000 total HCBS waiver and Habilitation enrollees showing that each waiver or Habilitation member's residence has been assessed for compliance with HCBS settings criteria multiple times.

Approximately 111 were "flagged" as requiring some sort of follow-up with the case manager to understand the context of the negative response. Almost all issues were addressed within ten days of initiation of the follow-up. Two of the flags were escalated to the provider for remediation. Both were remediated through collaboration with the member's interdisciplinary team and updates to the member's person-centered plan.

All providers of residential services have demonstrated compliance with HCBS settings requirements with or without modifications. None were identified as unwilling or unable to comply, but some may

have stopped providing HCBS services in a non-compliant setting or disenrolled from residential services rather than complying.

Three providers operating residential SCL or Home-Based Habilitation service settings were determined to meet Category 3 of heightened scrutiny and will be put forward for heightened scrutiny review. Two more providers operating residential RCF settings meeting Category 3 of heightened scrutiny will follow once Iowa completes a review of the new locations. These settings are all new settings that required assessment for compliance with HCBS settings criteria and meta category of heightened scrutiny.

Again, Iowa has submitted a CAP to CMS to complete validation of assessments results by specific settings and to complete heightened scrutiny review activities.

VIII. Ongoing Monitoring

Iowa will continue to monitor settings for compliance with HCBS settings requirements after the end of the transition period. Initial assessment efforts were focused on identifying, assessing, and remediating provider owned or controlled non-residential service settings (i.e., adult day care settings, day habilitation settings, employment settings) and provider owned or controlled residential service settings (i.e. settings where traditional and host-home models of SCL, Home-Based Habilitation, RBSC are provided) and settings where HCBS is provided in licensed facilities including RCF and ALF. Ongoing monitoring includes quality oversight review of the same provider owned or controlled settings included in the initial assessment phase as well as all other HCBS residential and non-residential settings.

The initial assessment process revealed opportunities for improvement to Iowa's ongoing monitoring processes and tools. Enhanced tracking tools will allow Iowa to more readily demonstrate which locations were toured and when and tie quality oversight review outcomes to specific settings.

As described in previous sections of the STP, Iowa is updating the Residential Assessment Tool to ensure the tool, which is the main assessment tool for HCBS provider owned or controlled and member owned and controlled residential settings, includes assessment of all HCBS settings criteria. Other enhancements to the tool will allow for consistency in data entry and therefore more uniform and useable data collection. An example of the limitation on the current form was previously provided related to the free text cell for entering the address of the residential setting. Another example that will be corrected with the update is that the services provided in the setting as well as the providers of those services is also free text entry. The update will allow for checkboxes to select the services provided in the setting and the name of the provider(s) will be automatically validated against Iowa's provider manager system. These enhancements will allow Iowa to report the individual residential settings where the uniformly identified HCBS are provided and verify the setting has been assessed for compliance with all HCBS settings criteria. In addition, a training is being developed to ensure all case managers, the administrators of the Residential Assessment, receive consistent, competency-based training on HCBS philosophy, the case manager's role in ensuring Iowa's compliance with HCBS settings requirements and person-centered planning, and proper completion of the Residential Assessment. The training will ensure all case managers understand the requirement to complete a Residential Assessment annually. This will ensure that every HCBS residential settings receives ongoing monitoring for compliance with HCBS settings criteria annually.

While residential HCBS settings will be assessed on a one-year cycle, non-residential HCBS settings will be assessed on a five-year cycle. The Focused Review operates on a five-year cycle so every provider receives a Focused Review at least once per five-year cycle. The topic of the Focused Review changes each year. Going forward, one year of each five-year cycle will be focused on monitoring of HCBS

settings compliance in non-residential service settings in which all non-residential settings will receive the Focused Review.

Other processes have been established or enhanced to ensure all HCBS settings remain compliant ongoing. Iowa Medicaid is developing an Informational Letter to inform all providers of the need to notify Iowa Medicaid when establishing a new location that requires assessment for compliance with HCBS settings requirements and potentially a heightened scrutiny review and approval from CMS. This will ensure all new settings are identified and reviewed prior to receiving HCBS funding in the setting. Quality oversight reviews (Periodic, Certification, Targeted and applicable Focused Reviews) now include tours of settings so that, over time, all provider owned or controlled settings will be specifically visited and reviewed by the QIO HCBS Unit on a regular basis. For HCBS residential settings, this would be in addition to the Residential Assessments administered annually by the member's case manager.

IX. Conclusion

Iowa Medicaid has ensured compliance with the final rule prior to March 17, 2023 and established an ongoing monitoring system to ensure continued compliance. Discrepancies and limitations with tools and processes have been identified and corrections and updates have already been started. Iowa has submitted a CAP to CMS to allow for additional time to remediate any settings found through CMS heightened scrutiny review to be out of compliance and to allow for additional time to complete validation of initial assessment results and heightened scrutiny activities.

X. Attachments

Attachment A

PREVIOUS STATEWIDE TRANSITION PLANS(STP)

ALL PUBLISHED STP AND DRAFTS

<https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans>

MARCH 2015 STP VERSION 1.1:

https://dhs.iowa.gov/sites/default/files/StatewideWaiverSettingsTransitionPlanRev3-6-15_0.pdf?011120232002

JANUARY 2016 STP VERSION 1.2

https://dhs.iowa.gov/sites/default/files/Approved_Initial_STP_Submitted.pdf?011120232003

APRIL 2016 STP VERSION 1.3

https://dhs.iowa.gov/sites/default/files/HCBS_Settings_Statewide_Plan_April_2016.pdf?011120232000

AUGUST 2016 APPROVED INITIAL STP VERSION 1.4:

https://dhs.iowa.gov/sites/default/files/Approved_Initial_STP_Submitted.pdf?011120232003

DECEMBER 2019 STP VERSION 1.5:

<https://dhs.iowa.gov/sites/default/files/FINAL%20STP%2012.19.19.pdf?122020191642>

JULY 2022 STP VERSION 1.6:

<https://dhs.iowa.gov/sites/default/files/2022%20STP%20Final%20Draft%20-%207.8.2022.pdf?011120232005>

Attachment B

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) FEEDBACK AND QUESTIONS SUMMARY

This attachment includes the feedback and questions from CMS to Iowa after each submission of the STP starting with the July 2022 STP Version 1.6. Prior feedback can be found imbedded into previous versions of the STP found on the Iowa Medicaid Statewide Transition Plan [website](#). Iowa's responses to questions and feedback from November 2022 are outlined below with links to the sections within STP Version 2.0 where a full response can be found, if applicable. The November 2022 Feedback and Responses are first with the July 2022 Feedback and Responses found after.

November 2022 Feedback and Responses

CMS Feedback

The CMS feedback and state responses at the beginning of the STP should be removed or included in its own Appendix as an attachment to the STP. The state should instead include any changes or updates directly to the body of the STP in the applicable sections. The bifurcation of information has created inconsistencies throughout the STP as discussed in this section below.

Tables and references to data should include a date to clarify what point in time the data represents.

Iowa's Response

Tables and references to data within STP Version 2.0 now include dates to clarify the point in time or date span that the data represents.

CMS Feedback

The state has at times included updates directly in the STP, while maintaining outdated information. Please clarify each section to reflect the process that was ultimately followed.

Iowa's Response

Response: [Please see this explanation within the STP regarding the process that Iowa followed for Version 2.0.](#)

CMS Feedback

Throughout the STP there is some concern regarding the state's classification of settings and should be aligned across the STP. Please see the following examples:

Figure 3, pg. 12, the settings listed in the "presumed not to be HCBS compliant," would more appropriately be named "Settings Required to be Assessed to Meet the HCBS Settings Rule Criteria."

Iowa's Response

Response: [Iowa concurs and has updated the figure per CMS recommendations and aligned language to match throughout the STP Version 2.0.](#)

CMS Feedback

Additionally, it is unclear how geo-mapping was initially used to determine how settings fell into these classifications.

Iowa's Response

Response: Please see this section for an explanation of how [geo-mapping](#) was initially used to determine how settings fell into classifications of “settings that are not HCBS”, “settings presumed to be HCBS compliant” and “settings required to be assessed for HCBS settings criteria”.

CMS Feedback

The state has broken down settings by classification on pgs. 4- 7 which do not align with how they are broken down in Figure 3 as well as many of the other figures in the response section of the STP. For instance, pg. 6, C. Settings presumed not to be HCBS compliant outline the settings that would fall under the three prongs of heightened scrutiny, while the figures seem to mean all settings that need to be assessed. The descriptions provided below Figure 3 do not align with these initial classifications on pgs. 4-7 as well.

Iowa's Response

Response: [Iowa concurs and has updated the figure per CMS recommendations and aligned language to match throughout the STP Version 2.0.](#)

CMS Feedback

CMS suggests the state use the following classifications for provider owned or controlled settings as it relates to their compliance classification, and apply it across the STP:

- Fully compliant with the HCBS settings criteria;
- Could come into full compliance with modifications during the transition period;
- Cannot comply with the HCBS settings criteria; or
- Are presumptively institutional in nature, but for which the state will submit evidence for the application of heightened scrutiny.

Iowa's Response

Response: Iowa did not track compliance in provider owned or controlled settings in this manner.

CMS Feedback

The state has used setting types, providers, and services interchangeably at times throughout the STP.

Iowa's Response

Response: Iowa has clarified throughout the STP Version 2.0 when talking about providers versus services and settings types by using full phrases such as “provider of day habilitation services” (provider), “day habilitation center” (setting) or “day habilitation services” (service).

CMS Feedback

It is recommended the state create a table that includes each settings classification and the specific settings types that fall under each category.

Example:

State's Classification	Setting Type
Settings presumed to be HCBS Compliant	Member's private home.
	Individual supported employment settings in community businesses
	100% community-based "no walls" day service settings (individual based, when individuals are not grouped together for the purpose of receiving services.)
HCBS Settings Required to be Assessed for the HCBS Setting Criteria	<ul style="list-style-type: none"> • Licensed residential settings • Residential Care Facility • Host Homes • Group Homes • Assisted Living • Supported Community Living (provider owned or controlled) • Adult Day Care • Prevocational settings • Supported employment when grouped together • Foster Care (if providing HCBS services) • Etc.
Not HCBS	<ul style="list-style-type: none"> • Nursing Facilities • IMD • ICF/ID • Hospital

Iowa's Response

Response: [Iowa concurs and has updated the figure per CMS recommendations and aligned language to match throughout the STP Version 2.0.](#) Some of the settings types listed in the example are the same thing in Iowa. For example, licensed residential settings are the same thing as Residential Care Facilities and Assisted Living and what is typically called a group home is more often referred to as a provider owned or controlled residence where Supported Community Living, RBSCCL for children and Home-Based Habilitation services are provided using a traditional or host home model of service delivery.

CMS Feedback

Please clarify the states compliance validation data of the provider self- assessments for each setting by settings type and compliance finding. Please see the Overall Compliance Validation Data Chart example below.

The state should ensure all settings types are included beyond those listed in the example.

The state should also ensure the validation results reflect the totality of all of the provider owned or controlled site-specific settings in the HCBS Medicaid system in the state, including those that cannot comply and have or will disenroll.

This should include Foster Care settings where HCBS is provided by the foster care parents, and host homes where individual's do not live in their own home, and instead live with an unrelated paid caregiver.

The table on pg. 55 includes much of the information needed, but would need some modifications to adequately reflect the information needed, in addition to the points outlined above:

- “Total # of settings assessed” should instead reflect the total number of settings in the HCBS delivery system.
- An additional column should be added to reflect the number of settings that Cannot or will not comply with the HCBS settings criteria. These would include those settings that have been disenrolled.

Note: Additional feedback items throughout the document directly connect to this chart as well.

Example of Overall Compliance Validation Data Chart:

Results	Non-Residential Settings				Residential Settings			Total
	Adult Day Care Centered Based	Day Habilitation	Prevocational Services	Supported Employment	Residential* “daily” SCL including Host Homes, some RCF, “group homes”	RCF	Assisted Living	
Fully compliant	10	0	5	2	100	1	50	168
Can comply with modifications	20	10	10	5	10	2	100	157
Cannot comply	1	0	0	2	0	0	0	3
Will submit evidence for the application of HS	2	2	0	1	0	0	5	10
Total	33	12	15	10	110	3	155	338

Iowa’s Response

Response: Iowa concurs and will adjust the STP Version 2.0 as able. As was conveyed through technical assistance calls with CMS, Iowa did not track compliance in a way that allows validation results to be depicted as suggested by CMS. For settings where non-residential services are provided, this could be achieved with additional time. For settings where residential services are provided, several steps have been taken to ensure results are tracked as suggested by CMS but it may not be possible to compile previous compliance results in the same manner. For now, Iowa has provided a narrative [response](#) to validate that all settings have been assessed through a combination of annual provider self-assessment, Residential Assessment of individual member’s residences, and quality oversight Periodic or Certification or applicable Focused Reviews. A [chart](#) was included in STP Version 2.0 demonstrating assessment results from the SFY17-18 Focused Review project which assessed settings where non-residential services are provided. The data in

this chart comes from a previous STP but is presented in a different way to provide the details requested by CMS.

CMS Feedback

Of the providers and their settings in the two bullets above (• Pg. 54 indicates there was a provider unable to develop a CAP to come into compliance, and disenrolled. • Pg. 41 indicates 41 providers cannot become compliant, but does not indicate the type of setting or how many settings fall under the 41 providers), the state should include the number of settings, setting types in the Overall Compliance Validation Data Chart under the compliance category of cannot or will not comply. Please see an example of the overall data validation the state should include in the STP in feedback above in the overarching concerns section.

Iowa's Response

Response: Iowa concurs and will adjust the STP Version 2.0 as able. The chart titled [Number of Providers Disenrolled by Service](#) shows the number of providers that have disenrolled by each service since 2014. Iowa does not track the reason for disenrollment for providers so some of these providers may have disenrolled for reasons other than inability or unwillingness to comply with HCBS settings rules. The chart shows disenrollment for the entire service. Iowa does not enroll by service setting but rather each provider enrolls for the desired services. A provider may disenroll from a single service or disenroll entirely. The chart does not account for providers who discontinued services in a certain setting but remained enrolled for the service (i.e. closed one center where day habilitation services are provided but did not disenroll from the day habilitation service and may continue providing it in another location).

CMS Feedback

The state identified the following services as being delivered in settings that need to be assessed on pg. 36-37. Please clarify what settings these services are delivered in and if they are included in the chart:

- Home-Based Habilitation
- Interim Medical Monitoring and Treatment
- Mental health outreach
- Supported Community Living
- Residential-Based Supported Community Living for Children.

The state should update the chart on pgs. 51-53 to align with the responses above. Both the Interim Medical Monitoring Treatment and the Mental Health Outreach have not changed in the chart. Additionally, when the state changed the key from “X” and highlighted sections to “X” and “O” it appears the designations have been transposed and should be realigned.

Iowa's Response

Response: The chart that CMS is referencing has been updated per CMS's recommendations and is found here [HCBS Waiver and Habilitation Services by Setting Types](#). A narrative response was also provided and can be found in the following sections of STP Version 2.0:

- [An explanation of all services by waiver or Habilitation that are subject to quality oversight can be found here.](#)
- An explanation of the [HCBS Waiver and Habilitation Services by Setting Types chart](#) is found here along with a response to the question about IMMT and Mental Health Outreach services.

CMS Feedback

The settings in which the following services are delivered in should be designated in the STP and included in the Overall Compliance Validation Data chart; Home-Based Habilitation, Supported Community Living, and Residential-Based Supported Community Living for Children.

Iowa's Response

Response: As discussed in technical assistance calls, Iowa did not track individual residential settings in the requested format. [A narrative explanation of available data is located here.](#)

CMS Feedback

The Overall Compliance Validation Data Chart should include how many of each setting there are for residential care facilities and host homes, and how many of each of the settings was in each compliance category of; Fully compliant with the HCBS settings criteria; Could come into full compliance with modifications during the transition period; Cannot comply with the HCBS settings criteria; or Are presumptively institutional in nature, but for which the state will submit evidence for the application of heightened scrutiny.

Iowa's Response

Response: As discussed in technical assistance calls, Iowa did not track individual residential settings in the requested format. [A narrative explanation of available data is located here.](#)

CMS Feedback

Pg. 38-39 The state indicates there are house, apartment, member residential and duplexes. It is not clear what services are provided in these settings and if they are provider owned and controlled. The chart on pg. 16 newly includes settings by some of the types the state has discussed in the STP, but does not list all residential settings types, or the compliance findings in general. These too should be included in the Overall Compliance Validation Data Chart. Please see an example of the overall compliance validation data the state should include in the STP in feedback above in the overarching concerns section.

The chart indicates there are 72 providers of Supported Employment that were assessed. Please clarify if this is group supported employment. The state can presume individual supported employment is compliant and should not include that in the chart. Group supported employment assessments must be validated by the state for each settings where group supported employment is received.

Please clarify if supported employment is always provided on an individual basis or if individuals can be grouped or clustered together to receive this service. If this service is always individual, the state can remove it from the provider owned or controlled settings category and from the Overall Compliance Validation findings and include it only in the ongoing monitoring. If individuals can be grouped or clustered together, the state will need to provide the compliance validation findings data in the chart and quantity by specific settings opposed to by provider.

Iowa's Response

Response: The chart titled [Results of Non-Residential Settings Assessments](#) shows the compliance results of assessed supported employment settings and is located here. An explanation of individual versus group supported employment is found [here](#).

CMS Feedback

The number of settings in the chart do not align with the number of settings in other areas of the STP. Pg. 47 there are 174 assisted living facilities listed under residential settings while the chart indicates there are 80 ALFs.

It is not clear in the state's response and STP the genesis of the ALF setting discrepancy. The state should clarify, after applying the validation by the state, how many ALF settings there are, and what the compliance finding is for each and include that in the Overall Compliance Validation Data Chart. Additionally, the state indicated in their response on pg. 18 that ALFs that fell under any of the three prongs of heightened scrutiny, all remediated before July 1, 2020 and currently there are no ALFs meeting the category for heightened scrutiny with outstanding remediation. Please indicate how many settings fell into one of the three prongs of heightened scrutiny, which prongs they fell under, and please note any ALF that fell under prong 1 (settings in the building as a public or private institution) or prong 2 (settings on the grounds of or adjacent to a public institution) must be submitted for heightened scrutiny if the state believes the settings overcomes the institutional presumption and is in fact HCBS. These settings should also be reflected in the Overall Compliance Validation Data Chart.

Iowa's Response

Response: This data may be provided with additional time.

CMS Feedback

Pg. 44 indicates 11 prevocational providers currently do not comply while the chart indicates there are 9. Pg. 44 indicates there are 110 non-residential settings in the state while the chart indicates a much higher total for non-residential settings.

Please label the charts with the point in time dates that are being referenced. Please consider moving outdated charts to an appendix and assure the information included in the Overall Compliance Validation Data Chart reflects those settings that do not or would not comply.

Iowa's Response

Response: Charts and data provided in previous STP versions was removed from the STP Version 2.0. The charts and data are still available in the STP versions for which they were originally created. Iowa created a [Results of Non-Residential Settings Assessment](#) chart to depict the outcomes of non-residential settings reviews with the details recommended by CMS. Iowa has communicated to CMS through technical assistance calls about the need for additional time to put the residential settings in the same format.

CMS Feedback

Provide additional details pertaining to Iowa's validation process. Provide more detail confirming that settings were assessed on all requirements of settings as outlined in the federal HCBS rule. Please also explain how providers were prompted to respond to questions in the assessments, i.e. yes/no responses, narrative responses, etc. Were providers asked to attach evidence along with their completed self-assessments to support their responses? If so, please describe the evidence submitted.

Iowa's Response

Response: Copies of the Annual Provider Quality Self-Assessment, Residential Assessment, and other assessment tools are found in the attachments and demonstrate the format of the questions and responses. Evidence of the validity of the provider's responses on the Annual Provider Quality Self-Assessment is reviewed through the quality oversight process as described in this [section](#).

CMS Feedback

Please clarify if all of the HCBS settings criteria were accounted for in the member assessments since there seemed to only be three main questions at the end that determined compliance. Please clarify who completed the member assessments for each of the delivery systems and that they were completed without conflict of interest. It is not clear how the state validated the member assessments when the responses to the main questions were “yes”. Please clarify this validation process. Additionally on Pg. 19 the state describes the process for provider self-assessments and onsite visits but does not indicate how the residential provider self-assessments are reviewed and validated. Please clarify.

On pg. 22 the state indicates that each outcome on the member assessment includes a series of questions to be answered by the case manager and later goes on to say the case manager may go on to ask additional questions of the member. Please clarify who is providing responses to the member assessment.

Iowa’s Response

Response: Details of how the Annual Provider Quality Self-Assessment, Residential Assessment, and other assessment tools are administered and used in determining compliance can be found [here](#).

CMS Feedback

Please clarify the role of the Iowa Participant Experience Survey (IPES) in validating the provider self-assessments and in ongoing monitoring. If this is an added layer and is not intended to be a strategy for validating individual settings’ self- assessments and ongoing monitoring, please make that clarification.

If the IPES wasn’t used to address site specific compliance please clarify that as well, and clarify how the state will incorporate the following feedback into the process in order to make IPES a site-specific monitoring tool:

- How the state accounts for all HCB setting criteria in the residential member assessment. Neither the nine-member personal outcomes listed on pgs. 21-22 or the Residential Settings Member Assessment linked to Attachment C cover all HCBS setting criteria such as the ability to lock bedroom door, opportunity to have visitors at any time, access to food at any time.
- How IPES are tied back to specific settings.

The state has indicated in the response section that the IPES were not used for validation but went on to say it was used in the quality oversight including focused reviews and certification, which were the validation strategies the state outlined. Please clarify this discrepancy, and if the IPES were used in the quality oversight process, please clarify if the IPES were site specific. If they were not site-specific, please clarify how they were used in the quality oversight process to help determine compliance findings.

Iowa’s Response

Response: The purpose and process for administering and using IPES data in determining compliance with HCBS settings can be found [here](#).

CMS Feedback

How the case manager ensures the member’s perspective is fully represented in the member assessment responses (i.e., provider staff responses may not be considered free of conflict).

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

What actions were taken when participants responded “no” in regard to compliance with settings criteria, were settings placed on a CAP?

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

Please clarify how the state is validating the provider-self assessments outside of the member survey in a way that it is clear all HCB settings criteria, in all HCB settings are being validated.

Additionally, pg. 41 indicates, “If a provider had more than 40 HCBS waiver members enrolled in services, five files were reviewed. If a provider had less than 40 HCBS waiver members enrolled in services, three files were reviewed. If a provider had multiple non-residential site locations, a member from each location was selected.” Please clarify how the state assured with efficacy that the setting was meeting the settings criteria, if only one file may have been received per setting in some instances.

Iowa’s Response

Response: This has been determined to be a statically valid representative sample for quality oversight reviews. More members may be selected to provide a more representative sample when with large providers or when providers are enrolled for several services.

CMS Feedback

If accurate, please attest in the STP that all settings have received a site-specific validation by the state, and that all of the HCBS settings criteria were assessed for.

Iowa’s Response

Response: Please see the [Validation of Results](#) section.

CMS Feedback

Additionally, the state has indicated an address collection process was used to determine specific settings in the state. The state also notes that numerical discrepancies are often a result of providers overreporting data. Please clarify how the state verified the addresses were of provider owned or controlled settings, or if the state was reliant on self-reported data. If the state used the self-reporting please clarify how the entire universe of settings that need to be assessed and validated was determined.

Additionally, if the state will be including drop down options on the next annual address collection tool which will newly include “host homes” please clarify how these settings have been identified, assessed, and validated by the state at present, and incorporate those determinations into the Overall Compliance Validation Data Chart.

Iowa’s Response

Response: The address collection process, purpose and 2022 updates are described [here](#).

CMS Feedback

CMS requests a detailed description of how the state will address settings for which providers do not complete the self-assessment. Additionally, please provide additional detail on the methodology used by the state to calculate the scores of the self-assessments.

Please clarify if any residential service providers received CAPs following the member assessments.

Please clarify the process for validation for settings that did not complete a self-assessment and if they received a CAP. Please clarify how many settings received a CAP.

Please clarify remediation CAPs were site specific and not only provider specific. Additionally, please clarify how many settings received a CAP initially after the state's validation of the provider self-assessments were completed.

Iowa's Response

Response: The Annual Provider Quality Self-Assessment, purpose and 2022 updates are described [here](#). Provider Quality Self-Assessments are not scored and all HCBS providers of services listed [here](#) are required to submit a Provider Quality Self-Assessment.

The Residential Assessment process including how follow-up on flags is carried out is located [here](#).

CMS Feedback

Individual, Privately-Owned Homes: The state may make the presumption that privately-owned or rented homes and apartments of people living with family members, friends, or roommates meet the home and community-based settings requirements if they are integrated in typical community neighborhoods where people who do not receive HCBS also reside. A state will generally not be required to verify this presumption. However, as with all settings, if the setting in question meets any of the scenarios in which there is a presumption of being institutional in nature and, the state determines that presumption is overcome, the state should submit to CMS necessary information for CMS to conduct a heightened scrutiny review to determine if the setting overcomes that presumption. In the context of private residences, this is most likely to involve a determination of whether a setting is isolating to individuals receiving HCBS (for example, a setting purchased by a group of families solely for their family members with disabilities using HCBS services). The state must also address how it tracks these settings through its ongoing monitoring process to ensure they remain compliant through the transition period and into the future. Please articulate how the state has done this analysis, and how these settings will be monitored over time.

Please clarify how the state has included private homes in their ongoing monitoring process. Additionally, please verify the state has included in their assessment process settings in which an individual lives with an unrelated caregiver who provides HCBS.

This feedback was not addressed. Please clarify how the state has included settings presumed compliant into their ongoing monitoring process. Additionally, please confirm the state has not included settings in which individuals live with unrelated caregivers who are paid to provide HCBS as individual's private homes and presumed compliant. Confirm that they are included in the provider owned and controlled settings assessment and validation process.

Please clarify the process the state is using to complete ongoing monitoring of settings that are presumed compliant and the cycle in which it is being completed. For example, the state has indicated in their response when a case manager is completing the assessment for the HCBS settings criteria, if a person indicates they are in their own home, live with family, or are renting, the case manager does not proceed with the assessment. The state should have an ongoing monitoring process in place for these settings, and any other settings initially presumed compliant where HCBS services are received, such as individual supported employment. The state should add this information to the applicable ongoing monitoring section on Pg. 73.

Iowa's Response

Response: Member owned and controlled residences (individual member homes) are presumed to be HCBS compliant but may still be reviewed through a quality oversight process as described [here](#) and in the section about [settings presumed to be HCBS compliant](#)

Response: The Residential Assessment process including how follow-up on flags is carried out is located [here](#).

CMS Feedback

Non-Disability Specific Settings: Please provide more specific details demonstrating how the state will assure beneficiary access to non-disability specific settings in the provision of residential and non-residential services. This additional information should include how the state is strategically investing to build capacity across the state to assure non-disability specific options.

Please clarify what the state is doing in order to build capacity of non-disability specific settings in the state. CMS can provide TA if the state requests assistance.

This feedback was not addressed. Please clarify what the state is doing in order to build capacity of non-disability specific settings in the state. CMS can provide TA if the state requests assistance.

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

The following additional information related to site-specific remediation is requested.

- Provide details about how Iowa identify settings that can comply with the rule with remediation.
- Include interim milestones for the remediation process. A reasonable remediation process and general timeline are provided, but interim milestones are not specifically broken down. For example, in the table regarding Site-specific Assessment Outcomes, the state indicates that a corrective action plan (CAP) will be initiated for settings that require remediation. Please provide a specific timeline for when the CAPs will be completed, evaluated, and implemented.

The state indicates on pg. 34 that there is no specified length of time for providers to complete the changes outlined in the CAP. Please provide a timeline by which providers must complete the CAP in enough time for the state to verify remediation has occurred prior to March 17, 2023.

While the state has provided details around the length of time a provider has to complete a CAP, it is not clear a date by which a setting must come in with a CAP in time to complete remediation and have the state verify compliance, before the end of the transition period. There also needs to be time for the state to transition individuals into other settings if the provider cannot resolve the CAP in order to become compliant. Please clarify a date certain, by which all providers must have CAPS submitted.

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

Additionally, the chart starting on pg. 55 indicates ongoing monitoring is completed through the HCBS Provider Quality Management self-assessment and onsite reviews. This does not seem to fully encompass the ongoing monitoring process laid out on Pg. 73, and could be misinterpreted to mean

ongoing monitoring is being completed through the self-assessment which would not be adequate. Please remove this column from the chart or further clarify it.

Iowa's Response

Response: The chart that CMS is referring to was removed from STP Version 2.0. It remains a part of the STP version for which it was originally created.

CMS Feedback

The following additional information regarding the heightened scrutiny process is requested.

- Clarify how the state is identifying sites it may present for heightened scrutiny, when it expects to have identified those sites, and when the state expects to put forth evidence for heightened scrutiny review to CMS. With regards to the proposed end date of 6/30/18 for the submission of Heightened Scrutiny evidence, CMS encourages the state to consider moving up this deadline in light of the fact that the state currently plans to complete many of its site-specific assessment activities, as well as its data matching and state determination related to heightened scrutiny by the end of 2016. Heightened scrutiny settings not identified until 6/30/18 may result in insufficient time for additional remediation or communication processes to be completed by the March 17, 2019 compliance deadline. CMS highly encourages the state to submit settings for heightened scrutiny review on a rolling basis.
- Describe how the state will identify settings (both residential and non-residential) that may have the effect of isolating individuals. Additional information on settings that isolate can be found at Medicaid.gov. CMS suggests to use Appendix A to identify potentially problematic settings (both residential and non-residential).
- Include additional interim milestones for the heightened scrutiny process with end dates, where possible. For example, within the heightened scrutiny activities of data matching, state determinations and submission of evidence for heightened scrutiny—the state should provide a breakdown of individual activities and their date of completion. As is, the STP is unclear with regard to whether the state may still be submitting evidence for heightened scrutiny up until the end date of 6/30/18, and by what date the state plans to require applicable sires to submit corrective action plans.

Please clarify the process the state will use to determine whether a setting will be submitted to CMS for heightened scrutiny review.

Please also provide the setting type for the 12 settings identified by the state that will need to come into compliance before July 1, 2020 or will need to be submitted for heightened scrutiny review.

Please clarify the process by which the state will verify remediation has occurred in those 12 settings prior to July 1, 2020.

Please clarify the states internal process for determining whether a setting will come into CMS for Heightened Scrutiny including the determining factors and who will make those final decisions.

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

Please clarify how the state has identified settings that isolate. Geo-mapping will not help to identify the following qualities that have the effect of isolating beneficiaries from the broader community:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.

The state has sufficiently responded to this item in the response section. Please incorporate your response directly into the body of the STP.

CMS Feedback

Please clarify what type of setting the 12 settings were, that came into compliance before July 2020, and how the state determined they overcame the institutional presumption of being isolating.

The state should identify in their STP all settings meeting heightened scrutiny criteria including those that remediated. It is important to understand for all settings the type of setting it is and which prong under heightened scrutiny it fell. In previous iterations the state indicated there were 12 settings that had remediated prior to July, 2020. Please confirm all 12 of these settings fell under prong 3, settings that isolate. It appears from the update the state has made, some of these settings have remediated while others have not, pg. 27-28. Please clarify.

Iowa's Response

Response: See [here](#) for an explanation for the types settings identified as meeting a category of heightened scrutiny and whether or not Iowa determined any such settings for each category. This section also clarifies the twelve settings previously identified as meeting a category of heightened scrutiny and whether or not they remediated prior to the July 1, 2020 deadline. It also identifies providers operating settings who will be moved forward for heightened scrutiny review and why.

CMS Feedback

Please clarify what type of settings voluntarily transitioned individual as indicated on pg. 55 for the one residential setting, and the type and number of the non-residential settings that impacted 151 members.

Please clarify this information in the STP. Specifically, in the Overall Compliance Validation Data Chart under the settings that cannot comply.

Iowa's Response

Response: As discussed in technical assistance calls, Iowa did not track individual residential settings in the requested format but non-residential settings assessment results are located [here](#). A narrative explanation is located [here](#).

CMS Feedback

Communication with Beneficiaries of Options when a Provider Will Not Be Compliant: The STP needs to include a more detailed timeline and specific decision of how the state will ensure that beneficiaries are given the opportunity, the information and the supports to make an informed choice of alternate setting that aligns with the federal requirements. Please describe in greater detail the state's process for communicating with beneficiaries and their families when settings cannot be brought into compliance with the rule including:

- Identifying the estimated number of beneficiaries that the state may need to relocate, and tailor the state’s beneficiary relocation plan and timeline accordingly.
- A description of how all beneficiaries impacted by the need to access a compliant provider will receive reasonable notice and due process, including a minimum timeframe for that notice;
- A description of how the state will ensure that beneficiaries are given the opportunity, the information, and the supports to make an informed choice of an alternate setting that aligns with the federal requirements;
- Outlining a detailed relocation process with timelines, and describe how the state will protect beneficiaries impacted by a setting’s inability to provide services to those beneficiaries in the future, and who will be responsible for executing each step of the process; and
- A description of how the state will ensure that all critical services and supports are in place in advance of each individual’s transition.

CMS appreciates the state’s outline of operational procedures for assisting individuals to relocate to another setting. Please clarify a process by which the individual is given notice with associated timeframes, how the state will offer informed choice of alternative settings through person-centered planning, who is responsible for executing the planning and the process, and a description of how the state will ensure that all critical services and supports are in place in advance of each individual’s transition.

In addition, please clarify how many individuals have been relocated at this point in time for the settings that do not and will not comply, and an estimate of the number of beneficiaries that may be in non-compliant settings.

Please clarify a process by which the individual is given notice with associated timeframes, how the state will offer informed choice of alternative settings through person-centered planning, who is responsible for executing the planning and the process, and a description of how the state will ensure that all critical services and supports are in place in advance of each individual’s transition.

In addition, please clarify how many individuals have been, or could be receiving services from settings that do not and will not comply. The state had indicated there is one prong 2 setting but does not indicate the type of setting or how many individuals may be affected.

The state has indicated when case managers will be notified when somebody is residing in a setting that will not comply with the HCBS settings criteria. Please clarify a deadline by which individuals will be notified that provides enough time before the end of the transition period to transition or locate other alternatives. Additionally, please clarify how the state will ensure that all critical services and supports are in place in advance of each individual that transitions.

Additionally please clarify how many individuals are currently receiving services in settings that might not comply by the end of the transition period.

Iowa’s Response

Response: A description of Iowa’s process for transitioning members from non-compliant settings can be found [here](#).

CMS Feedback

The state is encouraged to assure that all materials are 508 compliant before going out for public comment.

Regardless of format, all Web content or communications materials produced are required to conform to applicable Section 508 standards to allow people with disabilities to access information that is in the statewide transition plan. We have reviewed your Statewide Transition Plan and found 508 compliance issues that need to be fixed before the document can be posted onto the CMS Website. The following is a list indicating some, but may not be all, issues identified:

- The title has failed.
- The page content has failed in tagged annotations on
 - The full table of contents, page 10 (3 items flagged), 12 (2 items flagged), 13, 14 (4 items flagged), 15 (3 items flagged), 16 (4 items flagged), 17, 18 (9 items flagged), 19 (3 items flagged), 20 (3 items flagged), 22 (2 items flagged), 27, 31 (4 items flagged), 49, 50, 56, 70 (18 items flagged), 74, 76, 79, 82 (6 items flagged), 83, 84 (8 items flagged), 85 (13 items flagged), 86, 87 (4 items flagged), 88, 89 (4 items flagged),90, 108
- Alternate text has failed in figures alternate text on
 - Pages 1, the tables on page 13, 26, 84 (2 items flagged), 85 (6 items flagged), 86 (6 items flagged), 87 (6 items flagged), 88 (5 items flagged), 89 (5 items flagged), 90 (3 items flagged), 91 (10 items flagged)
- Tables have failed in headers on
 - Pages 52, 55, 56, 70, 92-93, 95, 106, 108

For additional information on how to ensure Section 508 compliance for your submissions, please refer to the general information on 508 available at [NCRTM Accessibility Resources](#)

Iowa's Response

Response: Iowa has corrected issues identified here.

CMS Feedback

Please provide all raw comments from all the public comment periods for the Statewide Transition Plan.

One commenter asked assisted living regulations be changed to allow admittance of individuals with specific transferring needs. The state responded that ALFs are licensed and regulated through the Iowa Department of Inspections and Appeals for admission and retention of individuals. The state should address in the response, how the department responsible for the licensure and regulation of the ALFs ensures that the setting is accessible including how the state has assured this in the assessment of the licensure and regulation of these settings in the STP that has received initial approval. If the latter has not been completed for these settings providing Medicaid HCBS, please include the information in the STP for review.

Please update CMS on the request for all public comments.

Iowa's Response

Response: Raw public comments were presented to CMS via email on November 2, 2022. A summary of public comments and Iowa's responses can be found in [here](#).

CMS Feedback

Please clarify the Figures to have their own identifying number. For instance, there are two figures that are labeled "Figure 1"; Number of non-Residential Service Settings by Service and Number of Residential Settings by Type of Residence.

Iowa's Response

Response: Iowa has corrected this issue.

July 2022 Feedback and Responses

CMS Feedback July 2022

The state's validation results found in the Quality Oversight and Review Results Chart (the chart, pg. 38-39) should include the state's compliance results across all settings within the HCBS delivery system. Please clarify the following:

The state has not included settings that cannot comply:

- Pg. 54 indicates there was a provider unable to come into compliance, and disenrolled.
- Pg. 41 indicates 41 providers cannot become compliant but does not indicate the type of setting or how many settings fall under the 41 providers.

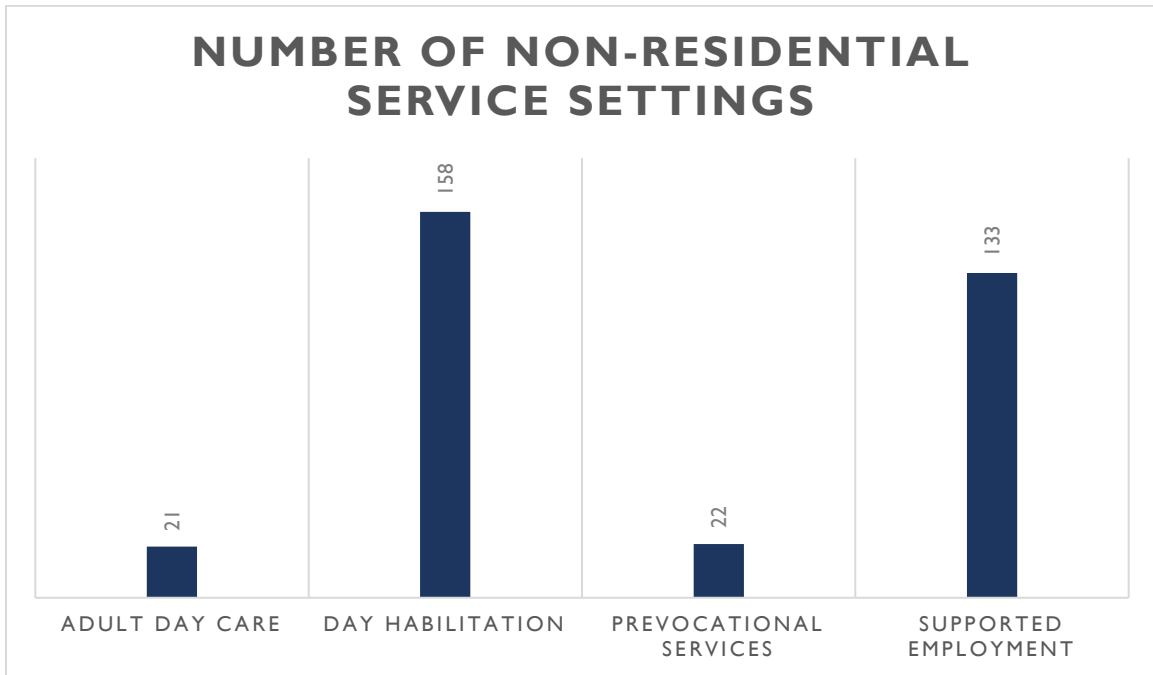
Iowa's Response October 2022

The chart on pages 38-39, now labeled [TABLE 5 NON-RESIDENTIAL SERVICES BY SETTING TYPE](#) of Iowa's July 2022 updated STP, is a point-in-time look at non-residential settings that were reviewed for compliance with settings criteria in SFY 17-18. "Non-residential services" included supported employment, prevocational services, adult day care, and day habilitation services. The chart is not meant to demonstrate all results across all settings within Iowa's HCBS delivery system nor was it updated since the chart was originally presented.

The chart on the top of page 41, now labeled [FIGURE 5 FOCUSED REVIEW RESULTS OF NON-RESIDENTIAL SERVICES PROVIDERS](#) and the surrounding, explanatory paragraphs were intended to be a point-in-time look at non-residential settings that were reviewed for compliance with settings criteria in SFY 17-18. It appears that at the time the chart was created, 41 non-residential service providers were either unable or unwilling to come into compliance with settings requirements and per the STP narrative, subsequently disenrolled from the non-residential services. The chart is admittedly unclear as to what type of settings are represented in this number aside from "non-residential" services which have already been identified as adult day care, day habilitation, supported employment, and prevocational services.

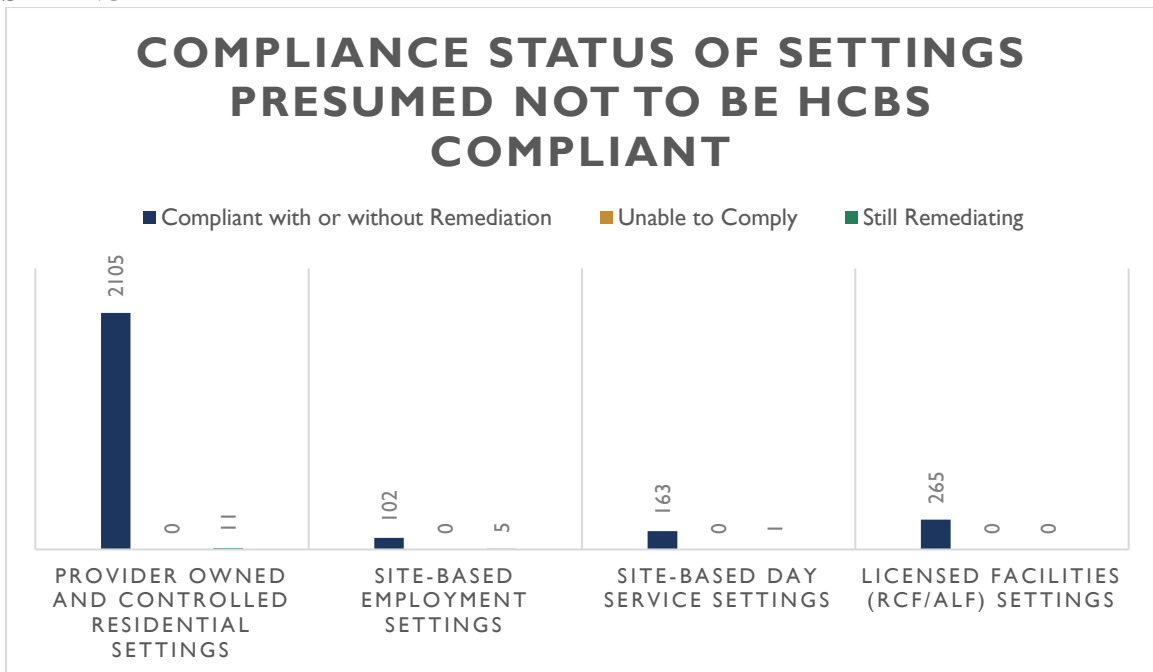
Current data from the 2021 address collection process shows that there are 108 distinct providers of non-residential services. Those 108 providers are enrolled for one or more of the non-residential services so that there are approximately 334 settings where adult day care, day habilitation, prevocational services and/or supported employment are provided. Providers may have erroneously over-reported individual employment locations such as local businesses as employment sites.

FIGURE 1 NUMBER OF NON-RESIDENTIAL SERVICE SETTINGS BY SERVICE



As of July 1, 2022, six (6) non-residential service settings are still in remediation to achieve full compliance with the HCBS settings rules. It is expected that all these settings will be able to achieve compliance or will voluntarily disenroll from non-residential services with which they are unwilling or unable to meet compliance. Also note that even though this response is primarily about the non-residential services, as of July 1, 2022, there were also 11 residential settings (7 providers) that were still in remediation to achieve full compliance.

FIGURE 2 COMPLIANCE STATUS OF SETTINGS PRESUMED NOT TO BE HCBS COMPLIANT BY SETTING TYPE



Section VIII. Summary of Initial HCBS Settings Discovery and Remediation Results the charts contained therein, intended to speak to efforts Iowa took to:

- Identify all residential and non-residential settings where HCBS services are provided and classify them as “Presumed to be HCBS”, Not HCBS, and “Presumed Not to be HCBS Compliant”.
- Establish a systematic process to review and assess the settings where members receive HCBS services to determine if each setting complies with the final rule and further classify them as “Able to Achieve Compliance with Modifications” or “Unable to Achieve Compliance”.
- Explain how settings “Able to Achieve Compliance with Modifications” will achieve and maintain compliance with the final rule.
- Establish a process for timely transition of members from settings that are “Unable to Achieve Compliance”.

Below is a clarified description of the activities outlined in Section VIII.

Identification of all residential and non-residential settings where HCBS services are provided and classify them as “Presumed to be HCBS”, Not HCBS, and “Presumed Not to be HCBS Compliant”.

After the establishment of the final rule in 2014, Iowa created and implemented the first “address collection” process as part of the existing annual HCBS Provider Quality Self-Assessment to gather preliminary details of all the settings where HCBS is provided across the state. All providers of services identified in section B of the annual self-assessment submitted a completed Address Collection Tool for the first time for the 2016 self-assessment.

Information from the initial address collection process was analyzed and geo-mapped allowing Iowa to initially identify all settings where HCBS is provided and classify them as:

- Settings that are HCBS and presumed to meet the final rule without any change required
- Settings that are not HCBS
- Settings presumed not to be HCBS Compliant
 - Able to Achieve Compliance with Modifications
 - Unable to Achieve Compliance
 - Able to Achieve Compliance without Modifications

The chart below shows each of the classifications and the types of HCBS settings in Iowa that were classified under each. Each classification is described in more detail after the chart.

FIGURE 3: IOWA'S HCBS SETTINGS CLASSIFICATION

Presumed to Be HCBS	Not HCBS	Presumed Not to be HCBS Compliant
<ul style="list-style-type: none"> • Member owned and controlled residential settings • Individual supported employment settings in community businesses • 100% community-based "no walls" day service settings 	<ul style="list-style-type: none"> • Nursing Facilities • IMD • ICF/ID • Hospitals 	<ul style="list-style-type: none"> • Site-based employment and day services • Licensed facilities, including RCF and ALF • Provider owned and controlled residential settings

Settings Presumed to Be HCBS

The first address collection process identified that most of the residential settings where HCBS is provided were member owned and controlled and most employment services were individualized and provided in integrated, community settings. Throughout the transition period, some providers of day services developed "no walls" models where members meet in the community and access the community throughout the entire service. Prior to the PHE, some day habilitation providers implemented programs that were entirely "no walls" while others offered this type of day service in addition to center-based activities.

All settings that have been classified as "presumed to be HCBS", continue to be subject to quality oversight review, including settings compliance review. Members living in member owned and controlled homes also receive a Residential Assessment at least annually. The Residential Assessment includes evaluation of whether the member's residential setting meets some basic settings requirements. Residential Assessment outcomes are validated through quality oversight reviews described [here](#).

Settings that are Not HCBS

Iowa's initial discovery process did not identify any settings defined as "NOT HCBS" meaning settings that are Nursing Facilities, IMD, ICF/ID, or Hospitals.

Settings Presumed Not to be HCBS Compliant

This classification is also sometimes described as "settings that are presumed to be institutional including settings that have the effect of isolating individuals from the greater community" or "presumed not to be HCBS". It was determined from the initial address collection project that Iowa had some settings that were presumed not to be HCBS compliant because of their institutional qualities or the effect of isolating individuals from the greater community. These settings needed to be evaluated to determine if the setting could comply with modifications. This is where Iowa concentrated the settings evaluation efforts. The following types of settings were classified as "presumed not to be HCBS compliant" and required evaluation:

- Site-based employment and day service settings

- Provider owned and controlled residential settings, and especially residential settings that are
 - Licensed facilities like Residential Care Facilities (RCF) and Assisted Living Facilities (ALF)

The QIO HCBS Unit began a project to evaluate these settings for the ability to comply and, for those that could comply with modifications, to ensure modifications were successfully carried out. This project was the Focused Review of non-residential service settings as described throughout section VIII. Additionally, Iowa created the Residential Assessment tool and process which is administered by case managers, to evaluate residential services settings as described [here](#).

Ability to Achieve Compliance

Settings that were classified as presumed not to be HCBS compliant were further considered as “able to achieve compliance with modifications”, “unable to achieve compliance”, or “able to achieve compliance without any modifications”. See [FIGURE 3 COMPLIANCE STATUS OF SETTINGS PRESUMED NOT TO BE HCBS COMPLIANT BY SETTING TYPE](#).

CMS Feedback July 2022

The state identified the following services as being delivered in settings that need to be assessed on pg. 36-37. Please clarify what settings these services are delivered in and if they are included in the chart:

Iowa’s Response October 2022

- Home-Based Habilitation
-

The Home-Based Habilitation service can be delivered in either provider owned and controlled, or member owned and controlled, residential settings and is included in the chart on pages 36-37, now labeled as [TABLE 3 HCBS WAIVER AND HABILITATION SERVICES](#), as a setting that is “subject to the setting assessment process”. More accurately, this is to say that the service of Home-Based Habilitation is included in our quality oversight processes and could be classified as either “presumed to be HCBS” because it is provided in a member owned and controlled home, or it could classify as “presumed not to be HCBS” depending on the model of service delivery in provider owned or controlled settings. Classification as “presumed to be HCBS” or “presumed not to be HCBS” would be discovered through regular quality oversight of each provider of Home-Based Habilitation services as would a determination of whether they could meet the HCBS standards with remediation and overcome the presumption of not being HCBS.

- Supported Community Living

This service can be delivered in either provider owned and controlled, or member owned and controlled, residential settings and is included in the chart as a setting that is “subject to the setting assessment process”. More accurately, this is to say that the service of Supported Community Living is included in our quality oversight processes and could be classified as either “presumed to be HCBS and meets the rule without any changes required” because it is provided in a member owned and controlled home, or it could classify as “presumed not to be HCBS” depending on the model of service delivery in provider owned or controlled settings. Classification as “presumed to be HCBS” or “presumed not to be HCBS” would be discovered through regular quality oversight of each provider of Supported Community Living services as would a determination of whether they could meet the HCBS standards with remediation and overcome the presumption of not being HCBS.

- Residential-Based Supported Community Living for Children.

This is the same service as above but specific for children and is only provided in provider owned and controlled locations. RBSCL is included in the chart as a setting that is “subject to the setting assessment process”. More accurately, this is to say that the service of RBSCL is included in our quality oversight processes and could be classified as “presumed not to be HCBS”, depending on the model of service delivery in provider owned or controlled settings. Classification as “presumed not to be HCBS” would be discovered through regular quality oversight of each provider of RBSCL services as would a determination of whether they could meet the HCBS standards with remediation and overcome the presumption of not being HCBS.

- **Interim Medical Monitoring and Treatment**

It was later determined that the Interim Medical Monitoring and Treatment (IMMT) service, by definition, is provide only in integrated, community-based settings and should not have been included as “subject to the setting assessment process”. It is a service that is reviewed through regular quality oversight processes which includes the annual Provider Quality Self-assessment, ongoing, regular review processes as described in [section VI. C.](#) but it would more accurately be classified as “presumed to be HCBS and meet the rule without any changes required”.

- **Mental Health Outreach**

It was later determined that this service, by definition, is not provided in provider owned or controlled settings and should not have been included as “subject to the setting assessment process”. It is a service that is reviewed through regular quality oversight processes which includes the annual Provider Quality Self-assessment, ongoing, regular review processes as described in [section VI. C.](#) but it would more accurately be classified as “presumed to be HCBS and meet the rule without any changes required”.

Overall, [TABLE 3 HCBS WAIVER AND HABILITATION SERVICES](#) was intended to show which services in Iowa are subject to the final rule and which classification they would fall under. It is admittedly unclear and does not depict useful information to the final STP.

CMS Feedback July 2022

On Pg. 47 the state indicates there are residential care facilities and host homes that are not included in the chart.

Iowa’s Response October 2022

The chart on pages 36-37, now labeled as [TABLE 3 HCBS WAIVER AND HABILITATION SERVICES](#) only shows the HCBS waiver and Habilitation program and services available under each. It does not show the type of settings where the services are provided. Iowa categorized certain services as “residential” including Supported Community Living (SCL) and Residential Supported Community Living (SCL for children), Home Based Habilitation, Assisted Living Service, and the service called (Agency) Consumer Directed Attendant Care (CDAC). These residential services may be provided in variety of housing types but the housing type itself is not a “service”. However, the chart on page 47, now labeled as [FIGURE 12 RESIDENTIAL SETTINGS](#), does show the types of housing where the above named HCBS, residential services were being provided at a point in time, based off the submitted 2018 provider self-assessment and address collection tools.

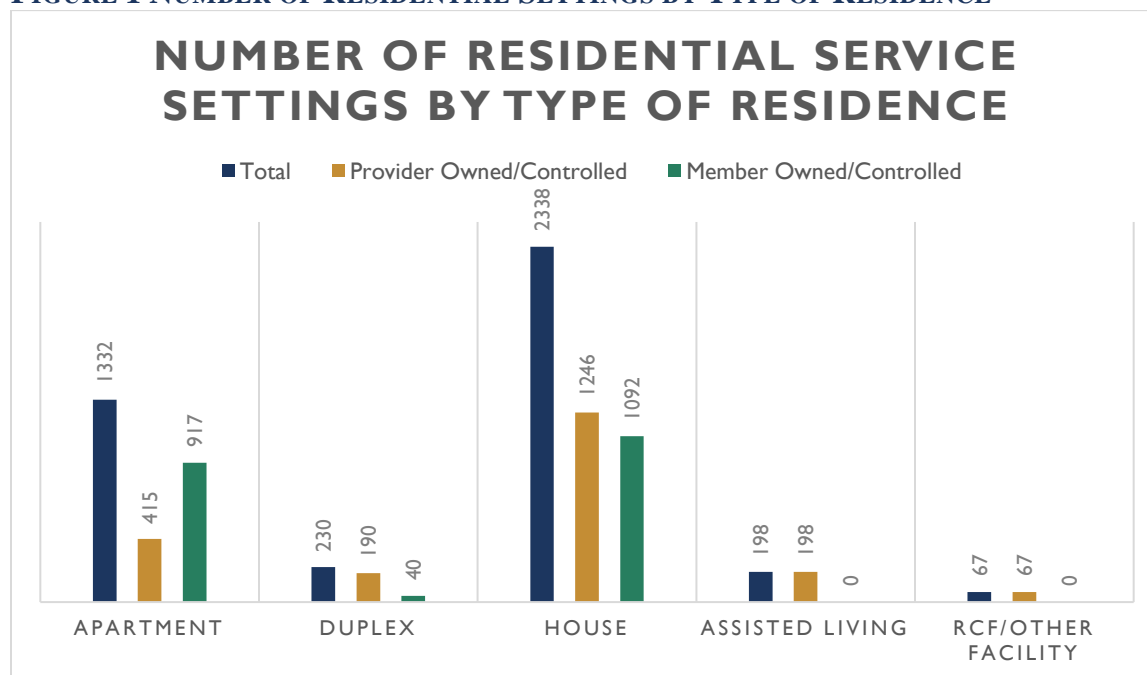
CMS Feedback July 2022

On Pg. 38-39 The state indicates there are house, apartment, member residential and duplexes. It is not clear what services are provided in these settings and if they are provider owned and controlled.

Iowa's Response October 2022

The chart on pages 38-39, now labeled as [TABLE 5 NON-RESIDENTIAL SERVICES BY SETTING TYPE](#), does not include information about “house, apartment, member residential and duplexes” so it is assumed that CMS is referring to the chart on page 47 titled “Residential Settings”, now labeled as [FIGURE 12 RESIDENTIAL SETTINGS](#). As described above, this chart showing the types of housing where the above named HCBS, residential services were being provided at a point in time, based off the submitted 2018 provider self-assessment and address collection tools. While providers are required to submit all provider owned and controlled locations where the residential services listed above are provided, they are not required to submit member owned and controlled locations where they provide the services listed above. However, many providers do over-report by including member owned and controlled locations in error. For this reason, there is a bar on the bar graph for “member residence” which is the voluntarily reported member owned and controlled locations from the 2018 provider self-assessment. Additionally, some of the “house” and “apartment” locations may be provider owned and controlled or member owned and controlled. Iowa has already taken steps to prevent reporting errors on the address collection tool so that data such as this is more reliable and consistent. Steps included enhancing the annual self-assessment training to emphasize what to report and how to properly fill out the tool. Additionally, the QIO HCBS team monitors the address collection tool submissions prior to approval to ensure they are properly completed. Future address collection tools will include some features to better prevent providers from incorrectly reporting and will better define and capture the housing types. Below is a chart of residential service settings by type of residence as reported through the 2021 address collection process.

FIGURE 1 NUMBER OF RESIDENTIAL SETTINGS BY TYPE OF RESIDENCE



CMS Feedback July 2022

The chart indicates there are 72 providers of Supported Employment that were assessed. Please clarify if this is group supported employment. The state can presume individual supported employment is compliant and should not include that in the chart. Group supported employment assessments must be validated by the state for each setting where group supported employment is received.

Iowa's Response October 2022

When a provider enrolls for HCBS waiver or Habilitation supported employment in Iowa Medicaid, they are enrolled for all types of supported employment including individual and small group. The chart on pages 38-39 now labeled as [TABLE 5 NON-RESIDENTIAL SERVICES BY SETTING TYPE](#), demonstrates that 72 supported employment providers were reviewed in the SFY 17-18 project to review non-residential service settings across the state. One of the purposes of that SFY 17-18 review project was to get a first look at the non-residential settings across the state and determine which ones would be classified as “presumed to be HCBS” or “presumed not to be HCBS compliant” and work with providers operating non-residential settings that fell into the “presumed not to be HCBS compliant” classification to achieve compliance and overcome the presumption of not being HCBS. According to the chart, all the supported employment provider settings were found to be HCBS compliant without a need for a change because all supported employment was found to be provided in community integrated settings. Like the issue described above, providers are required to use the annual address collection process to report the locations where they provide non-residential services, but they are not required to report individual supported employment provided in community-based businesses. However, many providers do over-report by including these locations in error. Iowa has already taken steps to prevent reporting errors on the address collection tool so that data such as this is more reliable and consistent. Steps included enhancing the annual self-assessment training to emphasize what to report and how to properly fill out the tool. Additionally, the QIO HCBS team monitors the address collection tool submissions prior to approval to ensure they are properly completed. Future address collection tools will include some features to better prevent providers from incorrectly reporting and will better define and capture information about settings where non-residential services are provided.

CMS Feedback July 2022

The number of settings in the chart do not align with the number of settings in other areas of the STP.

- Pg. 47 there are 174 assisted living facilities listed under residential settings while the chart indicates there are 80 ALFs.

Iowa's Response October 2022

Iowa concurs that it is unclear how the number of assisted living facilities in the chart of page 40, now labeled as [TABLE 6 ASSISTED LIVING SETTINGS](#), corresponds to the number of assisted living facilities reported by providers on the 2018 provider self-assessment. The chart is said to show the number of assisted livings that were reviewed for compliance with HCBS settings criteria at that point in time. It is believed that the review process being referred to in the chart is the regular review processes as described in [section VI. C](#). However, the chart on page 47, now labeled as [FIGURE 12 RESIDENTIAL SETTINGS](#), shows how many of each housing type were reported in the 2018 provider self-assessment and address collection. Assisted livings meeting heightened scrutiny category 1: physically attached to a publicly or privately-owned facility providing inpatient treatment or category 3: has the effect of isolating individuals, have been reviewed for compliance with HCBS settings requirements and all were able to achieve compliance prior to July 1, 2020. There are currently no assisted livings in Iowa that meet a category for heightened scrutiny with outstanding remediation.

CMS Feedback July 2022

Pg. 44 indicates 11 prevocational providers currently do not comply while the chart indicates there are 9.

Iowa's Response October 2022

It appears that the chart on page 38-39, now labeled as [TABLE 5 NON-RESIDENTIAL SERVICES BY SETTING TYPE](#), shows a different point in time than the narrative on [page 44](#) is talking about. The chart on pages 38-39 (TABLE 5 NON-RESIDENTIAL SERVICES BY SETTING TYPE) demonstrates that 69 prevocational services provider settings were reviewed in the SFY 17-18 project to review non-residential service settings across the state and 9 of them required some sort of remediation. The narrative on page [44 and 45](#) says as of March 2020, 11 prevocational providers were in the process of implementing some sort of remediation. As of July 1, 2022, four (4) prevocational service settings are still in remediation to achieve full compliance with the HCBS settings rules. It is expected that all these settings will be able to achieve compliance or will voluntarily disenroll from non-residential services with which they are unwilling or unable to meet compliance.

CMS Feedback July 2022

Pg. 44 indicates there are 110 non-residential settings in the state while the chart indicates a much higher total for non-residential settings.

Iowa's Response October 2022

It appears that the chart and the surrounding narrative are talking about two different points in time. [FIGURE 1 NUMBER OF NON-RESIDENTIAL SERVICE SETTINGS BY SERVICE](#) demonstrates the current number of non-residential service providers and settings of each type: day habilitation, adult day care, supported employment, and prevocational services.

CMS Feedback July 2022

Please clarify the role of the Iowa Participant Experience Survey (IPES) in validating the provider self-assessments and in ongoing monitoring. If this is an added layer and is not intended to be a strategy for validating individual settings' self-assessments and ongoing monitoring, please make that clarification.

Iowa's Response October 2022

The Iowa Participant Experience Survey (IPES) was an existing survey that Iowa completes with a statistically valid sample of HCBS waiver and Habilitation members. It existed prior to the HCBS settings final rule. It was noted that there are questions on the survey that could help Iowa's discovery process related to HCBS settings, especially as it relates to members' experiences in HCBS settings. The IPES is not intended to be a strategy for validating providers' responses on the annual provider self-assessments, but it is used as one piece of evidence in quality oversight periodic, certification, and focused reviews as described in [section VI. C](#). As a general overview, a certain number of members are selected for each quality oversight review. The member's record as maintained by the provider under review is used as a piece of evidence. Additionally, other evidence is obtained as applicable, including, but not limited to, any IPES that were completed with the selected members in the last year.

To best answer the question, it may be helpful to understand that quality oversight reviews as described in section VI. C. are the main method used by Iowa to determine compliance of HCBS waiver and Habilitation providers. There are several independent processes occurring that are drawn upon to inform Iowa's quality oversight reviews. Most processes existed prior to the implementation of the HCBS settings final rule but were either discovered to be useful tools for determining compliance with HCBS settings requirements or were enhanced and expanded to better inform the oversight of settings requirements. For example, Iowa has had a robust HCBS quality oversight system in place for over 30 years which has included regular, ongoing quality oversight review of providers of HCBS waiver and Habilitation services. In the early 2000's, the annual Provider Quality Self-Assessment was implemented to enhance the regular, ongoing review of providers. The self-assessment also includes an "attestation" whereby providers attest to the answers being true and accurate. Quality oversight review as described in section VI. C. , include validation and verification of the accuracy of responses on the annual provider self-assessment. To validate and verify answers, reviewers look at the provider's policies, procedures, quality improvement plans, and records in addition to any other available evidence such as incident and complaint data, tours of sites, and any existing member experience surveys.

With the introduction of the HCBS settings requirements in 2014, subsequent annual provider self-assessments were updated to include criteria related to HCBS settings requirements and the Address Collection Tool was established as part of the self-assessment, as a means of collecting the specific sites where HCBS was provided. Quality oversight review checklists which already corresponded directly to self-assessment, therefore expanded to include review of settings requirements. The initial Address Collection Tool also informed the initial geo-map as described [here](#), that helped Iowa to classify settings and discover which settings fell into one of the three categories of heightened scrutiny.

The QIO HCBS Unit structure is primarily built for quality review of providers, as opposed to quality review of members and specific locations. As described in [section VI. C.](#), providers may be enrolled for multiple services and although they have a "main office", they may operate many sites for each of the services they are enrolled to provide, serving many members across the state.

Some providers of certain services need "certification" from the QIO HCBS Unit to be eligible to enroll and provide the service. Others are simply subject to quality oversight from the QIO HCBS Unit. Every provider subject to HCBS quality oversight is selected for a periodic or certification review at least once per 5-year cycle or according to their certification end date. Every provider subject to HCBS quality oversight is selected for a focused review at least once per 5-year cycle. The topic of the Focused Review changes each year and is drawn from the self-assessment and corresponding periodic and certification review checklist. These quality oversight reviews are described in [section VI. C.](#) Additionally, the infographic below provides a picture of how the various surveys, assessments, and tools work together to provide HCBS quality oversight review decisions, including decisions about compliance with HCBS settings requirements.

FIGURE 2 HCBS QUALITY OVERSIGHT REVIEWS



CMS Feedback July 2022

If the IPES wasn't used to address site specific compliance please clarify that as well, and clarify how the state will incorporate the following feedback into the process in order to make IPES a site-specific monitoring tool:

Iowa's Response October 2022

While the IPES is not a site-specific assessment tool, Iowa did recently create a site-specific checklist to assess individual locations more consistently and comprehensively. This was done in response to CMS feedback to the previous submission of Iowa's STP and the realization that gaps existed between assessing providers and services rather than individual locations. This tool is used by the QIO HCBS Specialists who review the locations. It can be used independently to collect and document information learned through individual site review and it can be incorporated as a piece of evidence for any related quality oversight review activity. The current HCBS Waiver and Habilitation Setting Assessment Tool can be found in the STP as Attachment F.

- How the state accounts for all HCB setting criteria in the residential member assessment. Neither the nine-member personal outcomes listed on pgs. 21-22 or the Residential Settings Member Assessment linked to Attachment C cover all HCBS setting criteria such as the ability to lock bedroom door, opportunity to have visitors at any time, access to food at any time.

Iowa created the [Residential Assessment tool and process](#) which is administered by case managers, to evaluate residential services settings. There is an update to the tool in progress that will add questions specific to the CMS feedback.

- How IPES are tied back to specific settings.

As described above, the IPES was not intended to be a “site-specific” monitoring tool.

- How the case manager ensures the member’s perspective is fully represented in the member assessment responses (i.e., provider staff responses may not be considered free of conflict).

The residential assessment tool is intended to be administered by the member’s case manager. Responses would come directly from the member with some influence from the case manager’s professional observation and knowledge of the member’s communication style and abilities. After the update described above, a training is planned which will also include clearer instruction on administering the tool, how the information is used, and the remediation process for “flagged” responses.

- What actions were taken when participants responded “no” in regard to compliance with settings criteria, were settings placed on a CAP?

Specific to the residential assessments and IPES, negative responses to certain questions are “flagged” for follow-up and resolution by the member’s case manager. When a response is flagged on a residential assessment, an email is sent to the QIO HCBS Unit’s designated staff. The designated staff contacts the member’s case manager, listing the negative responses and asking the case manager to respond within 10 days. The case manager is asked to explain the circumstances around the negative responses and whether any remediation occurred at the member or provider level. Acceptable remediation would include an explanation of the action taken or changes in process or barriers to change. If an issue was discovered that was systemic to a provider, the provider’s assigned QIO HCBS Specialist would be notified for follow-up which could result in a corrective action.

- Please clarify how the state is validating the provider-self assessments outside of the member survey in a way that it is clear all HCB settings criteria, in all HCB settings are being validated.

Please see the previous responses which offer an in-depth explanation of the entire review process and how each member survey and piece of evidence is used to assess a provider and setting.

- Additionally, pg. 41 indicates, “If a provider had more than 40 HCBS waiver members enrolled in services, five files were reviewed. If a provider had less than 40 HCBS waiver members enrolled in services, three files were reviewed. If a provider had multiple non-residential site locations, a member from each location was selected.” Please clarify how the state assured with efficacy that the setting was meeting the settings criteria, if only one file may have been received per setting in some instances.

The member’s records are just one piece of evidence used to assure compliance, including compliance with settings criteria. Please see this [infographic](#) of the review process which better explains all the pieces of evidence used in our review processes.

CMS Feedback July 2022

Please clarify the process for validation for settings that did not compete a self-assessment and if they received a CAP. Please clarify how many settings received a CAP.

Iowa's Response October 2022

All providers of services subject to settings requirements must complete an annual provider self-assessment. Providers failing to submit a self-assessment are referred to Iowa's Program Integrity Unit for sanctions.

CMS Feedback July 2022

Please clarify how the state has included settings presumed compliant into their ongoing monitoring process. Additionally, please confirm the state has not included settings in which individuals live with unrelated caregivers who are paid to provide HCBS as individual's private homes and presumed compliant. Confirm that they are included in the provider owned and controlled settings assessment and validation process.

Iowa's Response October 2022

Iowa collects information about the environment where all HCBS waiver and Habilitation members reside through the residential assessment. See the screenshot below that shows part 1 of the residential assessment.

A setting would be presumed to be HCBS if any of these items are marked on the residential assessment so the case manager would not move on to the rest of the form which contains the "assessment" pieces. The "assessment" of the member's residence would only be completed if the

Member's residential setting (part 1). Please check all that apply. The member:

- Lives with their family or legal representative
- Owns their home, or
- Rents a living unit from a community landlord that is not owned or operated by a HCBS service provider

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

Member information of this assessment.

setting where they live is provider owned or controlled or meets one of the categories of heightened scrutiny. See the screenshot below that shows part 2 of the residential assessment.

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

- Located on the grounds of or directly adjacent to a public or private institution.
- A licensed facility (residential care, assisted living, other).
- Where two or more members receiving Medicaid funded services live together to receive waiver/habilitation service.
- Where multiple HCBS/habilitation living units are co-located in close proximity to each other within the community.
- Owned or operated by the provider of service.

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

Regarding your request to confirm that Iowa "has not included settings in which individuals live with unrelated caregivers who are paid to provide HCBS as individual's private homes and presumed compliant", it is assumed that CMS is asking this because part 1 of residential assessment only asks if the

member lives with “family” or legal representative. Iowa concurs that this could be clearer on the residential assessment, and this will be addressed in the update described earlier in this document. Additionally, the next annual address collection tool will ask providers to select which type of residence best describes the location from the following drop-down options which include “host homes”.

- Unit in multiplex (duplex, 4-plex, 8-plex, condos, apartment building, etc.)
- House (house, trailer, row house, townhouse)
- DIA licensed Residential Care Facility (RCF)
- DIA licensed assisted living facility
- Host Home
- Other: See Notes

CMS Feedback July 2022

Please clarify what the state is doing in order to build capacity of non-disability specific settings in the state. CMS can provide TA if the state requests assistance.

Iowa’s Response October 2022

Currently members using HCBS and Habilitation services have options to access residential and nonresidential services in non-disability specific community settings. This includes accessing services in residential settings that are typical types of housing available to anyone living in a community as well as non-residential settings that are fully integrated into community settings.

Most members accessing HCBS services live in residential settings that are neither provider owned and controlled nor a licensed facility. Residential options for members accessing HCBS include living with family or friends, rent from community landlords, or own their own home. These options allow members to receive services in their own home and within the community of their choice. It also allows members to have access to other non-disability specific community resources like grocery stores, shopping malls, churches, sporting events, restaurants, parks, and other entertainments settings and venues that all members of the community have access.

The HCBS program has worked with the Iowa Finance Authority (IFA) to assist members to access rental assistance in community-based housing. The IFA has been administering the Home and Community-Based Services (HCBS) Rent Subsidy Program since January 2005. This program provides temporary rental assistance for people who receive medical services through Medicaid 1915 (c) waivers until the person becomes eligible for another public or private rent subsidy.

The HCBS QIO unit has worked with non-residential providers to decrease reliance on center-based service provision. For example, some Day Habilitation providers have chosen to provide the service through a “Day Hab without walls” model where the provider no longer uses their Day Hab center and instead use only community-based settings for service provision. Other providers continue to use the Day Hab center as a starting point each day and offer service options that leave the Day Hab center and provided in integrated community settings.

HCBS day habilitation service rules were recently changed to expand opportunities and support for community inclusion and develop skills for active participation in integrated community employment. Prior to this rule change, the Day Habilitation services focused on community inclusion and participation in recreational activities and volunteering opportunities. Adding employment opportunities to the Day

Habilitation service has expanded member opportunity to receive Day Habilitation services in non-disability employment specific settings in addition to community based recreational settings

Supported employment settings are required to be integrated community settings where members receive employment supports in community businesses. These employment settings are based on the member's work interest and allows them develop work skills in non-disability work settings.

Iowa offers a self-direction program, the Consumer Choices Options (CCO), that is available to members that access six of the seven 1915(c) waivers. CCO gives a member choice and control a monthly budget that is used to get their service needs met. Using CCO supports a member to receive services in their home and community of choice and decreases reliance on receiving services from a provider agency. Approximately 10 to 12 percent of eligible member choose to use CCO self-direct some or all of their HCBS services.

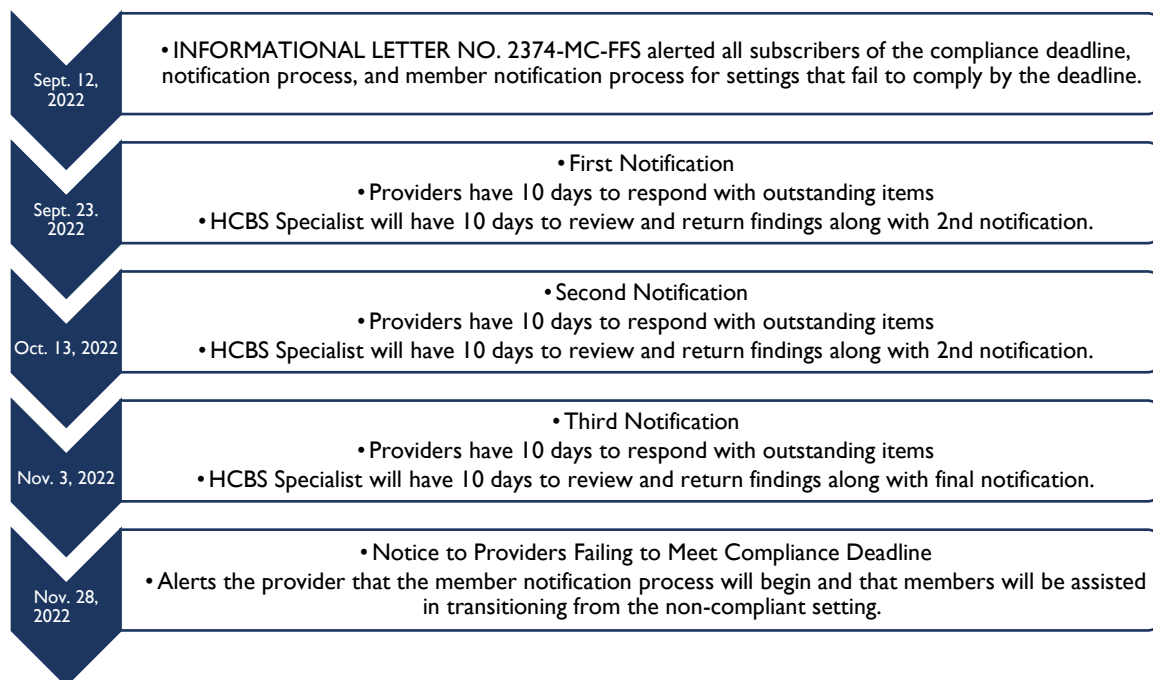
While Iowa has taken some action to assure members have access to non-disability specific settings during the provision of HCBS services, we will continue to assess the delivery of HCBS services to assure compliance with the settings regulations and expand opportunities to access services in non-disability specific setting. By December 31, 2023, the QIO unit will evaluate the current HCBS service providers and analyze the findings to identify service delivery options that will encourage more community integration, member autonomy, and choice of non-disability specific settings for individual members. Based on the evaluation and analysis, the QIO HCBS unit will develop and present training materials to providers and case managers to increase understanding and use of non-disability specific settings in the provision of HCBS services.

CMS Feedback July 2022

While the state has provided details around the length of time a provider has to complete a CAP, it is not clear a date by which a setting must come in with a CAP in time to complete remediation and have the state verify compliance before the end of the transition period. There also needs to be time for the state to transition individuals into other settings if the provider cannot resolve the CAP in order to become compliant. Please clarify a date certain, by which all providers must have CAPS submitted.

Iowa's Response October 2022

As of July 1, 2022, there were 11 residential settings (7 providers) and six non-residential settings (6 providers) that were still in the process of remediation related to settings. By the time the notification process described here was implemented in mid-September 2022, only 7 residential settings (5 providers) and 3 non-residential settings (3 providers) had not achieved compliance and received the notification letters. The following special notification process was implemented in September 2022 alerting these providers that they have what may be a shortened timeline to return an acceptable plan of remediation (CAP) or to fully implement an already approved remediation plan and therefore achieve compliance by Iowa's final compliance deadline of November 30, 2022. The final compliance deadline of November 30, 2022 allows Iowa Medicaid members receiving services in a setting that is unable or unwilling to achieve compliance more than three months to transition to a compliant settings or make alternative plans. See the timeline illustration below.



If any providers are operating settings that remain out of compliance by November 30, 2022, case managers who serve members receiving services in the setting or settings will receive a notice that the provider is unable to achieve compliance. The notice will explain that HCBS will no longer be funded at the location as of March 17, 2023, and that members will need to transition to a compliant setting for that service or make alternative plans. The case manager will be responsible for notifying the member and their legal decision makers and they will be responsible for ensuring the successful transition of members. Periodic check-ins with the members' case managers will be conducted by the QIO HCBS Unit until all members are transitioned or have made alternative plans. The deadline for having all members transitioned is March 17, 2023.

CMS Feedback July 2022

Please clarify the states internal process for determining whether a setting will come into CMS for Heightened Scrutiny including the determining factors and who will make those final decisions.

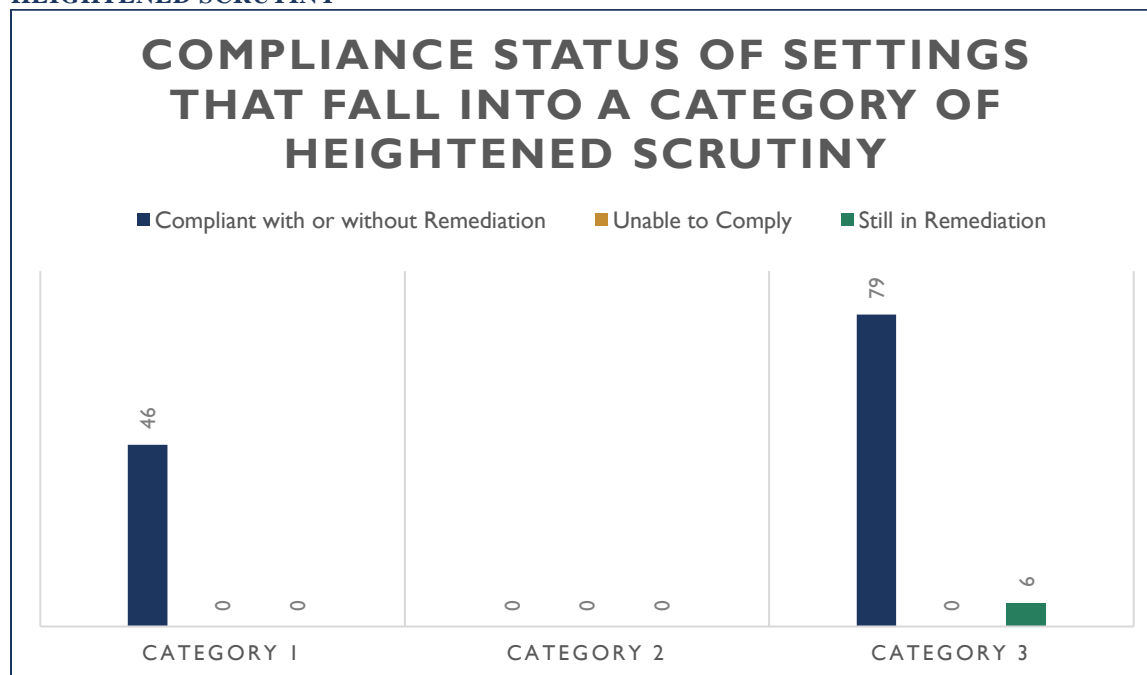
Iowa's Response October 2022

Providers operating settings that fall into one of the categories of heightened scrutiny have been identified through Iowa's various means of discovery including the annual provider self-assessment and address collection tool, residential assessment data, and quality oversight reviews. Settings determined to meet a category of heightened scrutiny are brought forward by the QIO HCBS Unit and vetted through the Statewide Transition Plan (STP) Workgroup and Iowa Medicaid leadership to decide if the setting should be submitted for public comment and on to heightened scrutiny.

FIGURE 3: IOWA'S HCBS SETTINGS CLASSIFICATION summarize Iowa's HCBS services including which residential and non-residential services fall into one of the classifications of Presumed to Be HCBS, Not HCBS, Presumed Not to be HCBS Compliant. Below is a chart showing which fall into one of the three categories for heightened scrutiny. The charts offer more details about the status of settings presumed not to be HCBS and whether they could meet the HCBS standards with remediation and

overcome the presumption of not being HCBS. Settings that meet one of the categories of heightened scrutiny and that have outstanding remediation related to settings are slated to be moved forward for public comment in October 2022 and then onto heightened scrutiny review after the public comment period.

FIGURE 33 COMPLIANCE STATUS OF SETTINGS THAT FALL INTO A CATEGORY OF HEIGHTENED SCRUTINY



CMS Feedback July 2022

Please clarify how the state has identified settings that isolate. Geo-mapping will not help to identify the following qualities that have the effect of isolating beneficiaries from the broader community:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary’s person-centered service plan.

Iowa’s Response October 2022

Providers operating settings that fall into one of the categories of heightened scrutiny, including Category 3, have been identified through Iowa’s various means of discovery including the annual provider self-assessment and address collection tool, residential assessment data, and quality oversight reviews. Geo-mapping was only used for the initial assessment of settings and to classify the setting as Presumed to Be HCBS, Not HCBS, or Presumed Not to be HCBS Compliant. Geo-mapping did help identify “clusters” of locations where HCBS settings are located around the state and clusters of settings could have an isolating effect on individuals.

CMS Feedback July 2022

Please clarify what type of setting the 12 settings were that came into compliance before July 2020, and how the state determined they overcame the institutional presumption of being isolating.

Please clarify what type of settings voluntarily transitioned individual as indicated on pg. 55 for the one residential setting, and the type and number of the non-residential settings that impacted 151 members.

Iowa's Response October 2022

The twelve providers identified in Iowa's 2019 STP Update are identified in the chart below. Some of them do remain out of compliance and may be moved forward to public comment and heightened scrutiny. Summaries will be provided with the heightened scrutiny submission that describe the settings and why they fall into a category of heightened scrutiny along with a summary of findings from any reviews and compliance follow-up that has been completed with the provider operating the setting. See below for information about the settings specifically named in previous versions of Iowa's STP.

FIGURE 44 PROVIDERS FOR HEIGHTENED SCRUTINY

Appendix B – Providers for Heightened Scrutiny	
Category 1: Services provided in a facility	Hillcrest RCF- IMD providing HCBS SCL and DH
Category 2: On the grounds or adjacent to a facility	None
Category 3-Settings that have the effect of isolation	<p>Mediapolis RCF with a day hab on the grounds of the RCF.</p> <p>Tenco Providing Pre-Vocation in a workshop limited to no integration.</p> <p>Senior Suites of Urbandale residential services are being provided in the same location as a residential care facility (RCF). AL services are in compliance with CMS settings and the RCF does not have any HCBS members. This agency did not receive a CAP in settings or person centered planning. This provider will not need to be submitted to CMS.</p> <p>Ragtime Industries Pre-Vocational services in a workshop setting</p> <p>One Vision Evidence of community integration lacking in a waiver home as there was not enough staff for members to go out into the community. Received a CAP, we are currently waiting on compliance material to see if they have corrected the issues.</p> <p>Park Place Agency is not documenting services so there is no evidence of integration. However the agency advised members come and go. They will have a Cap as the review was recent.</p> <p>Mosaic CB & Logan Agency was running apartment complex as a facility.</p> <p>Hills and Dales Seven members are living in two units on the same street. The unit is a duplex with a common laundry and community space in a lower level. No CAP required, all members had evidence of community integration. This site will not need to be sent to CMS.</p> <p>Eyerly Ball Agency provides DH in the same location as their RCF. No CAP required, evidence of community integration was provided. This agency will not need to be submitted for HS by CMS.</p> <p>Community Adult Residential Environment- Community integration was evident through the review process. This will not need to be submitted for HS review.</p> <p>Circle of Life Corrective action plan to address quarterly review of rights restrictions within the policy Also required update to "house rules". No setting issues and this will not need to be sent to CMS for HS review.</p> <p>Evergreen Estates</p>

7

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

Hillcrest ended HCBS services at this location.

Mediapolis was able to demonstrate that members spent a significant amount of time in the community through the day habilitation services even though the center was on the grounds of the RCF.

Senior Suites of Urbandale was determined to have the effect of isolating members because it was a licensed assisted living attached to or at the same location as an RCF. The RCF was not serving any members and the assisted living was determined to be compliant without the need for remediation.

Tenco ended HCBS services in this location and was later purchased by another entity.

Ragtime will be moved forward for HS review if they are unable to achieve compliance by November 30, 2022. They still operate a prevocational service setting in a “workshop” type of environment and have not been able to overcome the effect of isolating individuals from the community.

One Vision was able to resolve the staffing issues that led to the lack of community integration in the one location. They provided additional training to staff to make sure they understand the requirements of HCBS and they developed a process to specifically address what to do when a member wants to go somewhere and only one staff is working.

Park Place Agency demonstrated compliance by removing unnecessary food and other restrictions from member plans. They remediated documentation concerns and were able to demonstrate evidence of member community integration. They also were able to demonstrate remediation of concern surrounding restrictions and goals.

Mosaic of Council Bluffs and Logan made significant updates to the physical spaces in both locations by removing confidential member materials from common spaces and removing Mosaic office materials in common spaces. The CB location no longer operates like a facility. Service documentation demonstrates members integrating in their communities as they choose to.

Mosaic of Logan is still working on remediation and will be put forth for public comment and heightened scrutiny. They have drastically reduced the number of members they are serving in that location and began offering the other apartments as rentals to the general community.

Hills and Dales was determined to be compliant without the need for remediation.

Eyerly Ball was determined to be compliant without the need for remediation.

CARE ended the services that were found to be out of compliance.

Circle of Life removed their “house rules” document and are no longer using it. They are also completing quarterly rights restriction reviews and all plans and restrictions were consistent.

Evergreen Estates was determined to be compliant without the need for remediation.

CMS Feedback July 2022

Please clarify a process by which the individual is given notice with associated timeframes, how the state will offer informed choice of alternative settings through person-centered planning, who is responsible for executing the planning and the process, and a description of how the state will ensure that all critical services and supports are in place in advance of each individual’s transition.

In addition, please clarify how many individuals have been, or could be receiving services from settings that do not and will not comply. The state had indicated there is one prong 2 setting but does not indicate the type of setting or how many individuals may be affected.

Iowa’s Response October 2022

It is assumed that most, if not all settings that are currently working on remediation will be able to become compliant by the deadline of November 30, 2022. This chart shows the provider names and the setting location and how many members are currently served in the location and would therefore be affected if the provider is unable to comply by November 30, 2022.

Case managers are already responsible for ensuring a choice of service settings and services are provided to members through the interdisciplinary team (IDT) and person-centered planning processes. Case managers are responsible for knowing what the members they serve need and want and for being knowledgeable about and presenting to members the resources available in their communities.

Case managers who serve members receiving services in a setting or settings that fail to achieve compliance by the November 30, 2022 deadline, will receive a notice that the provider is unable to achieve compliance. The notice will explain that HCBS will no longer be funded at the location as of March 17, 2023, and that members will need to transition to a compliant setting for that service or make alternative plans. The case manager will be responsible for notifying the member and their legal decision makers and they will be responsible for ensuring the successful transition of members. Monthly check-ins with the members' case managers will be conducted by the QIO HCBS Unit until all members are transitioned or have made alternative plans. The deadline for having all members transitioned is March 17, 2023.

CMS Feedback July 2022

The state is encouraged to assure that all materials are 508 compliant before going out for public comment. Regardless of format, all Web content or communications materials produced are required to conform to applicable Section 508 standards to allow federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. We have reviewed your Statewide Transition Plan and found 508 compliance issues that need to be fixed before the document can be posted onto the CMS Website. The following is a list indicating some, but may not be all, issues identified:

- The document title needs to be linked with in the document.
- The bookmarks failed: that means that the table of contents isn't linked through the document which makes it hard to go to different pages.
- Table on page 37: don't have headers, and the table is not assessable because it uses colors to describe the information.
- Table headers failed: there are tables that don't have table header: 37, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90
- Figure needs to be labeled as decorative so that it doesn't pick up on the reader: page 1, 69, 70, 71, 72, 73, 74, 75.
- There also aren't page number for a lot of the pages so we went off the pages on Adobe acrobat.

Iowa's Response October 2022

Iowa will ensure these standards are fully implemented upon final approval.

CMS Feedback July 2022

Please provide all raw comments from all the public comment periods for the Statewide Transition Plan.

Iowa's Response October 2022

Iowa will provide the raw public comments below the summaries.

Attachment C

HOME- AND COMMUNITY-BASED SERVICES (HCBS) RESIDENTIAL SETTING MEMBER ASSESSMENT

I. Member information		
Member Name:	Member ID:	
Address:		
City:	Iowa	Zip:
HCBS Waiver:		
Services Received:		
HCBS Service Providers:		
Assessment Completed By:		Date:
DHS/MCO/IHH Unit:		
Please check: Initial Assessment Annual Assessment		
Number of Waiver or Habilitation members living in the setting:		
<p>Member's residential setting (part 1). Please check all that apply. The member: Lives with their family or legal representative Owns their home, or Rents a living unit from a community landlord that is not owned or operated by a HCBS service provider</p> <p>These settings are presumed to be integrated community settings. Members that meet one of these three settings and do not meet any criteria in part 2 below are required to only complete section I. <i>Member information</i> of this</p>		
<p>Member's residential setting (part 2). The following residential settings require additional review to determine compliance with the HCBS setting rules. Please check all that apply. The member lives in a setting that is:</p> <p style="padding-left: 20px;">Located on the grounds of or directly adjacent to a public or private institution. A licensed facility (residential care, assisted living, other).</p> <p style="padding-left: 20px;">Where two or more members receiving Medicaid funded services live together to receive waiver/habilitation service.</p> <p style="padding-left: 20px;">Where multiple HCBS/habilitation living units are co-located in close proximity to each other within the community.</p> <p style="padding-left: 20px;">Owned or operated by the provider of service.</p> <p>Members that meet any part 2 criteria shall have Section III. <i>Member Outcomes</i> of the HCBS Residential Setting Member Assessment completed by the assigned case coordinator (CBCM, CM or IHH). Assessments shall be conducted in person and in the home where the member lives. Initial assessments shall be conducted by December 31, 2017, and annually thereafter.</p>		
Please submit completed electronic assessments to:		

II. Instructions to Complete the Residential Assessment	
<p>Below are nine personal outcomes expected to be present in a member's life. Each outcome is listed separately and has a series of questions to be answered by the interviewer to assist with determining whether or not the outcome is present in the life of the member. The presence of these outcomes identifies characteristics of living in integrated community settings. There is no right or wrong answer to the outcome questions as the outcome defines the experience of the member in their residential setting.</p> <p>The list of questions is not inclusive and the interviewer may ask additional questions based on the response from the member. The interview must include the member and may include others (parents, guardians, provider staff, etc.) as needed. By asking the questions, the interviewer must have enough information to answer either yes or no on the final outcome question at the end of each section. If the interviewer cannot make a final determination, additional guidance questions are needed. For each Yes or No response, the interviewer must provide evidence that supports the final response.</p>	
III. Member Outcomes	
1. Members Choose where and with whom they live.	
<p>Guidance questions:</p> <ul style="list-style-type: none"> • Was the member given a choice of available options regarding where to live/receive services? • Is the setting in the community among other private residences? • Was the member given the opportunity to visit other settings? • Does the setting reflect the member's needs and preferences? • Was the member given a choice of roommates? • Does the member talk about his/her roommates in a positive manner? • Does the member have a choice in whether to share a room with a roommate? • If married, does the married couple have a choice in whether to share or not share a room? • Does the member know how the member can request a roommate change? • Does the member have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement? • Does the member know his/her rights regarding housing and when the member could be required to relocate? 	
Did the member choose where and with whom to live? (Yes or No)	Yes
<p>If YES, describe evidence/supporting documentation used to determine the response.</p> <p>If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.</p>	
2. Members choose their daily routine.	

<p>Guidance questions:</p> <ul style="list-style-type: none"> • Can the member come and go from the residence at any time? • Does the member talk about activities occurring outside of the setting? • Does the member participate in scheduled and unscheduled community activities? • Does the member choose when to get up in the morning, bathe, eat, exercise, participate in activities, etc.? • Does the member's schedule vary from others in the same setting? • Does the member have access to such things as a television, radio, and leisure activities that interest him/her and can the member participate in such activities at his/her convenience? • Does the member choose when and with whom to eat meals? • Can the member request or prepare an alternative meal if desired? • Does the member have access to snacks anytime? • Is the member required to sit at an assigned seat in a dining area? 	
Does the member make choices about day-to-day activities and routines? (Yes or No)	Yes
<p>If YES, please describe evidence/supporting documentation. If NO, identify how this is addressed in the member's person-centered plan.</p>	
<p>3. Members choose where they work or receive day services.</p>	
<p>Guidance questions:</p> <ul style="list-style-type: none"> • Does the member work in an integrated community setting? • Was the member given a choice of available options regarding where to work? • If the member would like to work, is there activity that ensures the option is pursued? • Was the member given the opportunity to visit other settings before making a choice? • Does the member participate in a day activity program? • Was the member given a choice of available options regarding where to receive day services including non-disability specific services? • When receiving day services, does the member participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the member? • Does the member have the opportunity to combine more than one service or type of day activity in any given day/week (e.g., combine competitive employment with community habilitation or day habilitation)? 	
<ul style="list-style-type: none"> • Does the member have residential service options available if work or day services are not chosen on any given day/week? 	
Does the member have the opportunity to seek employment and work in competitive integrated settings? (Yes or No)	Yes No
When not working, is the member active in the community outside of the residential setting and have opportunity to participate in integrated day services during typical work time hours of the day? (Yes or No)	Yes No
<p>If YES to either question, describe the evidence/supporting documentation used to determine the response. If NO to either, describe evidence/supporting documentation used to determine the response and identify how</p>	
<p>4. Members manage personal resources.</p>	

<p>Guidance questions:</p> <ul style="list-style-type: none"> • Does the member have a checking or savings account or other means to control his/her personal finances? • Does the member have access to his/her personal finances? • Is the member required to sign over his/her paychecks to the provider? • When needed, does the member receive support from direct care staff to manage personal funds? 	
Does the member manage personal resources to the degree desired by the member? (Yes or No)	Yes No
<p>If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.</p>	
<p>5. Members are treated with dignity and respect.</p>	
<p>Guidance questions:</p> <ul style="list-style-type: none"> • Does staff ask the member about her/his needs and preferences? • Are members aware of how to make a service request? • Does the member express satisfaction with the services received? • Are requests for services and supports accommodated as opposed to ignored or denied? • Is member's choice facilitated in a manner that leaves the member feeling empowered to make decisions? • Is health information about members kept private? • Are schedules of members for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view? • Are members, who need assistance with grooming, groomed as they desire? • Are monitoring cameras present in the setting? • Do staff or other residents always knock and receive permission before entering an individual's living space? • Do members greet and chat with staff? • Do staff converse with members in the setting while providing assistance and during the regular course of daily activities? • Does staff talk to other staff about a member as if the member was not present or within earshot of other persons living in the setting? 	
Is the member treated with respect? (Yes or No)	Yes
Does the setting assure member privacy? (Yes or No)	Yes
<p>If YES to either, describe evidence/supporting documentation used to determine the response. If NO to either, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.</p>	
<p>6. Members use community resources.</p>	

Guidance questions:

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

Does the member have opportunity to use the resources of the community? (Yes or No)	Yes
Does the member participate in community activities of interest to the degree desired by the member? (Yes or No)	Yes No
If YES to either, describe evidence/supporting documentation used to determine the response. If NO to either, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.	
7. Members have access to their home and community.	
<p>Guidance questions:</p> <ul style="list-style-type: none"> • Are there gates, Velcro strips, locked doors, or other barriers preventing members' entrance to or exit from certain areas of the setting? • Are members receiving Medicaid Home- and Community-Based services facilitated in accessing community-based amenities such as a pool or gym used by others? • Is the setting physically accessible and are there no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting members' mobility in the setting or, if they are present, are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction? • For those members who need supports to move about the setting as they choose, are supports provided, such as grab bars in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.? • Are appliances accessible to members (e.g., the washer/dryer is front loading for members in wheelchairs)? • Are tables and chairs at a convenient height and location so that members can access and use 	
Is the member's home and community accessible to meet the individual needs of the member? (Yes or No)	Yes No

<p>If YES, describe evidence/supporting documentation used to determine the response. If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.</p>
8. Member exercise their rights and responsibilities.
<p>Guidance questions:</p> <ul style="list-style-type: none"> • Are all limitations of individual rights clearly identified in the member's person-centered plan? • Is the member supported in voting in local, state, and national elections? • Is information about filing a complaint given to a member and in an understandable format? • Is the member comfortable discussing concerns? • Can the member file an anonymous complaint? • Does the member know the person to contact or the process to make an anonymous complaint? • Does staff impose arbitrary limits on a member? • Does the member have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement? • Does the member know his/her rights regarding housing and when the member could be required to relocate? • Do members know how to relocate and request new housing? • Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord-tenant laws?

Does the member understand and exercise their rights and responsibilities? (Yes or No)	Yes No
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If YES, describe evidence/supporting documentation used to determine the response.
 If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.

9. Services are individualized to the needs of the member.

Guidance questions:
 Does the member, or a person chosen by the member, have an active role in the development and update of the person-centered plan?
 Are individual wants, needs, and preferences incorporated into the member's person-centered service plan?
 If needed, does the member know how and to whom to make a request for a new provider?
 Is the member or a person chosen by the member, aware of how to schedule person-centered planning meetings?
 Can the member explain the process to develop and update a service plan?
 Was the member present during the last planning meeting?
 Did/does the planning meeting occur at a time and place convenient for the member to attend?
 Can the member identify other providers who render the services they receive?
 Does the member express satisfaction with the provider selected or has the member asked for a meeting to discuss

Are services provided to the member based on a person-centered plan developed to meet individual needs? (Yes or No)	Yes No
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If YES, describe evidence/supporting documentation used to determine the response.
 If NO, describe evidence/supporting documentation used to determine the response and identify how this is addressed in the member's person-centered plan.

IV. The Bottom Line

Based on the finding of the nine member outcomes above, answer yes or no to the following statements:

The member has access and opportunity to use the community resources to meet individual needs and preferences.	Yes No
The residential setting supports the member to live, work, and recreate in the community to the degree desired by the member.	Yes No
All rights limitations that limit access to the greater community are documented in the member's person-centered plan	Yes No

Attachment D

HOME AND COMMUNITY BASED SERVICES (HCBS)
PROVIDER QUALITY SELF-ASSESSMENT

For the 2022 version see the link below.

<https://dhs.iowa.gov/sites/default/files/470-4547.pdf?011320232322>

Attachment E

ADDRESS COLLECTION TOOL

Below are screenshots of each tab on the Address Collection Tool spreadsheet with the drop down options displayed.

Office Locations

PROVIDER NAME	ADDRESS	STREET	UNIT	CITY	STATE	ZIP
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Residential Settings										SERVICES PROVIDED IN THIS SETTING									
PROVIDER NAME	PROVIDER OWNED OR CONTROLLED SETTING	TYPE OF RESIDENCE	ADDRESS	STREET	UNIT	CITY	STATE	ZIP	HBH	RBSCL	SCL	CDAC AGENCY IN AN RCF OR ALF	ASSISTED LIVING SERVICE	NUMBER OF MEMBERS SERVED	NUMBER OF OTHERS SERVED	DIA LICENSED	5 PERSON APPROVAL	NOTES	
	Yes	Unit in multiples (duplex, 4-plex, 8-plex, condos, apartment building, etc.)							Yes	Yes	Yes	Yes	Yes			NA	Yes		
	No	House (house, trailer, row house, townhouse)							No	No	No	No	No			ALF	NA		
		DIA licensed Residential Care Facility (RCF)														3-5 Bed RCF			
		DIA licensed assisted living facility														8 Bed RCF			
		Host Home														12 Bed RCF			
		Other: Describe in "Notes" column														16 Bed RCF			
																Registered Boarding			
																Other: Indicate in notes			

Non-Residential Settings										SERVICES PROVIDED IN THIS SETTING									
PROVIDER NAME	PROVIDER OWNED OR CONTROLLED SETTING	TYPE OF NON-RESIDENTIAL	ADDRESS	STREET	UNIT	CITY	STATE	ZIP	ADC	DH	PV	SE	NUMBER OF MEMBERS SERVED AT THIS LOCATION	NUMBER OF OTHERS SERVED AT THIS LOCATION	NOTES				
	Yes	Adult day care or day habilitation site							Yes	Yes	Yes	Yes							
	No	Non-site based ADC or DH (aka "no walls" or "100% community based")							No	No	No	No							
		Prevocational services site																	
		Group supported employment site																	
		Other: Describe in "Notes" column																	

Attachment F

SETTINGS ASSESSMENT TOOL

The tool is to be completed by an HCBS Specialist when evaluating a Home and Community Based Service (HCBS) setting for compliance with HCBS settings requirements. A “setting” may also be referred to as a “site” or “location”. Likewise, “provider”, “organization”, “agency”, and “facility” may be used interchangeably.

*Please note that a setting assessment cannot be completed unless the setting has been established. Technical assistance is available from the HCBS Specialist regarding establishing a new HCSB site. This tool may still be used for assistance in planning for and establishing a site, but a compliance recommendation cannot be made until the setting is established and the setting assessment is completed.

**Please note that a newly constructed facility setting must take appropriate action PRIOR to receiving HCBS funding in the setting. For example, the setting must be 1) licensed by the appropriate licensing entity and must 2) be able to demonstrate compliance with HCBS settings requirements and be approved through a heightened scrutiny review from the Centers for Medicare and Medicaid (CMS). In order to demonstrate compliance, it is likely that they will need to serve non-HCBS funded individuals in setting for a period of time. Technical assistance is available from the HCBS Specialist regarding establishing a new HCSB site and obtaining approval from CMS prior to funding HCBS services in the location. This tool may still be used for assistance in planning for and establishing a site, but a compliance recommendation cannot be made until the setting is established and the setting assessment is completed.

ORGANIZATION AND SETTING DETAILS

Insert Photo of Site if appropriate.

Organization Name:	
Organization Address:	Phone:

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

FUNDING AND SERVICES IN THIS SETTING

Mark all funding sources and services provided in this setting.

HCBS Waiver/Habilitation	Service(s)
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<input type="checkbox"/> AIDS/HIV Waiver <input type="checkbox"/> Brain Injury Waiver <input type="checkbox"/> Children's Mental Health Waiver <input type="checkbox"/> Elderly Waiver <input type="checkbox"/> Health and Disability Waiver <input type="checkbox"/> Intellectual Disability Waiver <input type="checkbox"/> Physical Disability Waiver <input type="checkbox"/> Habilitation <input type="checkbox"/> Money Follows-the-Person (MFP) <input type="checkbox"/> Other:	<input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assisted Living Service <input type="checkbox"/> CDAC Agency <input type="checkbox"/> Day Habilitation <input type="checkbox"/> Home Based Habilitation <input type="checkbox"/> Prevocational services <input type="checkbox"/> Supported Community Living (SCL) <input type="checkbox"/> Residential-Based SCL for children (RBSCCL) <input type="checkbox"/> Supported Employment <input type="checkbox"/> Intensive Residential Service (IRS) <input type="checkbox"/> Other:
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ADDITIONAL DETAILS

List the number of HCBS funded members and non-HCBS funded members served in this setting.	HCBS funded: 0 Non-HCBS funded: 0
Is this setting provider owned or controlled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this setting an existing location or a new or prospective location?	<input type="checkbox"/> Prospective* <input type="checkbox"/> Existing <input type="checkbox"/> New (<input type="checkbox"/> **Check this box if the location is a newly constructed facility.)
How was it determined that the organization needs a settings-specific assessment?	<input type="checkbox"/> Residential assessment <input type="checkbox"/> Self-Assessment or Address Collection Tool <input type="checkbox"/> Quality oversight review <input type="checkbox"/> Incident or complaint <input type="checkbox"/> Referral or notification <input type="checkbox"/> Other:
What category of heightened scrutiny applies to this setting?	<input type="checkbox"/> NA <input type="checkbox"/> Category 1: Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment <input type="checkbox"/> Category 2: In a building on the grounds of, or immediately adjacent to a public institution <input type="checkbox"/> Category 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS <input type="checkbox"/> NA

<p>What subcategories apply to this setting (select all that apply).</p>	<p><input type="checkbox"/> HCBS in ALF that are physically attached to a NF</p> <p><input type="checkbox"/> HCBS in larger than 3-5 bed RCF</p> <p><input type="checkbox"/> HCBS (such as ADC, DH, employment services) in an RCF, NF, hospital, or other facility</p> <p><input type="checkbox"/> Setting limit individuals' opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS due to the design or model of service provision.</p> <p><input type="checkbox"/> Setting restricts members' choices to receive services or to engage in activities outside of the setting.</p> <p><input type="checkbox"/> Setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services.</p> <p><input type="checkbox"/> Clusters of sites including several units with people receiving HCBS in a multi-plex of any kind, clusters within neighborhoods, streets, communities, etc. that are clustered together by design for the purpose of receiving HCBS.</p> <p><input type="checkbox"/> Newly constructed or newly licensed facility</p> <p><input type="checkbox"/> Site is/was a facility converted to HCBS*</p> <p><input type="checkbox"/> Quality of care concern related to HCBS settings requirements</p> <p><input type="checkbox"/> Site-based employment service such as a "sheltered workshop"</p> <p><input type="checkbox"/> Other:</p>
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EXPLANATION

Home and Community-Based Services (HCBS), whether residential or nonresidential, must be provided in integrated, community-based settings that support members' full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS. HCBS services are required to be provided in such a way as to optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact. If an individual requires a restriction or limitation in one or more of the areas listed below, due process of that restriction or limitation should be outlined in their person-centered plan. Policies and procedures related to restrictive interventions should be followed. Answer the following questions about the location(s) identified to determine the level of compliance with the HCBS Settings rules and to identify areas in need of corrective action.

DESCRIPTION OF SETTING

Please provide a general description of the setting and the reason for the setting assessment. The description should include but is not limited to the following.

- A description of the location within the community.
 - Describe the surrounding community, neighborhood, and neighbors.

- Describe any other offices, businesses, or services provided at the same location.
- Describe the proximity to community resources such as public transportation, recreation, cultural and religious activities, and shopping.
- For sites that have been remodeled or newly constructed, explain what modifications have been made and how the renovations/construction ensures HCBS settings requirements are met.
- A description of the physical characteristics of the site.
 - Describe the floorplan, the number of bedrooms, and available common areas.
 - Explain if the residential site is a single-family home or a unit or units in a multiplex or something else.
 - For non-residential sites, explain access to the site by the general community.
 - Describe the entrances and exits and any distinction between the those used by members, staff, and the general community.
 - Explain how there is a meaningful distinction between HCBS services and institutional care that is or was provided in/ adjacent to/attached to the same location or in combination with institutional care.
 - Explain how the location is accessible to the members served there.
- A description of any physical characteristics of the location or physical building that supports or fails to support HCBS settings requirements.

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SETTING ASSESSMENT SUMMARY

Explain the reason for the settings assessment and a summary of findings after assessing the setting. The description should include but is not limited to the following.

- Highlights from the assessment checklist below that support or do not support the organization's compliance with HCBS settings requirements.
- Establish the organization's/setting's ability or inability to overcome institutional presumptions and to demonstrate a meaningful distinction between institutional settings and HCBS.
- Establish the organization's/setting's ability or inability to overcome the effect of isolating individuals receiving Medicaid HCBS from the broader community.
- Describe what has been done to ensure members have a non-institutional experience in the newly established HCBS setting.
- Explain what has been implemented to prepare staff for providing HCBS services, especially if the staff are transitioning from an institutional setting to an HCBS setting.
- Explain whether other quality oversight activities (i.e. the most recent self-assessment, the most recent onsite or related desk review, applicable residential assessments, etc.) with the organization support or do not support observations from onsite tours, interviews and information from the organization about this setting, and findings from this settings assessment. If the organization has been required to take corrective action related to HCBS settings requirements in the past, explain the issue and how they were able to achieve compliance.

Did the organization attest to being compliant with HCBS settings requirements in the same or similar settings on their most recent Provider Quality Self-Assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No: EXPLAIN
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Does the organization operate other HCBS sites that have been determined through their most recent Quality Oversight Review to be compliant with HCBS settings requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No: EXPLAIN

COMPLIANCE DECISION

Name and title of person who completed this setting assessment:	
Date this setting assessment was completed:	
<p>Compliance Status and Recommendations</p> <input type="checkbox"/> Evidence supports that the setting is compliant with HCBS settings requirements. Organization is required to maintain ongoing compliance with all HCBS requirements. <input type="checkbox"/> Evidence supports that the setting is NOT compliant with HCBS settings requirements. <ul style="list-style-type: none"> <input type="checkbox"/> Setting could/did meet requirements for HCBS Settings with remediation. <ul style="list-style-type: none"> o Date remediation plan (CAP) accepted: o Date remediation (CAP and compliance) achieved: <input type="checkbox"/> Setting is unable or unwilling to meet requirements by compliance deadline. <input type="checkbox"/> Other:	
<p>Next Steps</p> <input type="checkbox"/> No further action necessary <input type="checkbox"/> Remediation required (<i>HCBS Specialist to initiate a full quality oversight review</i>) <input type="checkbox"/> Post for public feedback (<i>HCBS Specialist to complete a package of evidence summary.</i>) <input type="checkbox"/> Refer to CMS further heightened scrutiny review <input type="checkbox"/> Other:	

CHECKLIST

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

I. SETTINGS-RELATED POLICIES AND PROCEDURES	
a) Are the organization's policies and procedures aligned with HCBS settings requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s): NA	
<p>b) Is the organization ensuring staff providing HCBS services, understand and effectively implement the HCBS settings requirements, especially if the staff are transitioning from an institutional setting to an HCBS setting?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> It is recommended that at a minimum staff receiving training on HCBS settings rules, the difference between institutional versus HCBS, member rights in HCBS, restrictive interventions in HCBS, member choice in HCBS, and other training required for HCBS organizations. 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>c) For settings 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 (Categories 1-2), is the organization effectively implementing policies and procedures to ensure the setting overcomes the institutional presumption?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>d) For settings that have the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS (Category 3), is the organization effectively implementing policies and procedures to ensure the setting overcomes the isolating effect it has on individuals?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
2. PHYSICAL LOCATION AND CHARACTERISTICS	
All Settings	
<p>a) Is the setting integrated into the greater community, allowing members full access to community resources and amenities such as but not limited to: essential and non-essential shopping, recreation, restaurants, religious services, exercise, healthcare, personal grooming services, and opportunities for competitive and integrated employment?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	

If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
b) Is the setting located so that there is not an overconcentration or isolation of HCBS or HCBS members in a certain area? THINGS TO CONSIDER: <ul style="list-style-type: none"> • In a residential setting, is the residence a unit in a multi-plex (apartment building, quadraplex, duplex, boarding home) where most of the other units are occupied by people receiving HCBS? • In a residential setting, is the residence located in a neighborhood, on a street, or on a block where other homes are occupied by people receiving HCBS? • Is the setting co-located with other HCBS services or institutional care? • Is the setting disability specific meaning that only people with a disability or specific disability may attend or live in the setting? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
c) Is the setting located in an area that facilitates members' ability to access community resources without being totally dependent on the service organization to access them or if limitations exist, have adaptations been made to facilitate members' access?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
d) Does the setting have available public transportation options or, where public transportation is limited, are other means of transportation available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
e) Is the setting physically accessible with no obstructions such as steps, lips in a doorway, or narrow hallways limiting members' mobility in the setting or if they are present, have environmental adaptations been made to ameliorate the obstruction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

<p>f) Does the setting allow for unrestricted access to the full setting?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Do members have full access to typical facilities in a home such as a kitchen with cooking facilities, laundry, and comfortable seating in the shared areas? Do members have access to the same amenities such as a pool or gym used by others on-site? Are there gates, Velcro strips, locked doors, or other barriers preventing members' entrance to or exit from certain areas of the setting? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<p>Explain:</p>	
<p>If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):</p>	
<p>g) Do members have privacy in the settings where your organization provides HCBS?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Are there cameras, postings of member-specific information such as schedules, toileting needs, medications, and restricted diets? Does the setting offer a secure place for the individual to store personal belongings? Are there private spaces available for personal care? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<p>Explain:</p>	
<p>If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):</p>	
<p>h) Is there a meaningful distinction between HCBS services and institutional care that is or was provided in the same location?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Is there shared programming (meals, transportation, social/recreational activities) between the different homes/buildings/services? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<p>Explain:</p>	
<p>If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):</p>	
<p>Provider Owned and Controlled Residential Settings</p>	
<p>i) Is the setting a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

<p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Is the space/unit being used as it is zoned, would be used by the general public, or otherwise intended? For example, if a unit is reported as a single unit, are addresses, utilities, entrances, and the physical space consistent with that definition? 	
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>j) Are members aware of their relocation and housing rights?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Would the member be required to move from the home for any reason? What rights does the member have under such circumstances? How are the members rights communicated to them so that they can make an informed decision prior to choosing this setting? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<p>k) Are entrance doors to the member's house and/or bedroom able to be closed and locked by the member with only appropriate staff having keys?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain: There are no members currently living in the site	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>l) Do members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
3. MEMBER EXPERIENCES IN THE SETTING	
<p>a) Are members' rights to initiative, autonomy, and independence in making major life choices optimized and not regimented?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Choices might include but are not limited to, daily activities, physical environment, and with whom to interact. 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

b) Is the setting where the member lives or receives services selected by the member from available options including non-HCBS specific options?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
c) Do members choose their roommates or housemates if sharing spaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
d) Are members able to have visitors of their choosing at any time as applicable to the setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
e) Are members allowed to come and go from the setting as desired?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain: Members	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
f) Do members control their personal resources?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
g) Do members have the freedom and support to control their own schedules and activities? THINGS TO CONSIDER: <ul style="list-style-type: none"> • Are members made to share staff, programming, meals, transportation, or social/recreational activities between nearby settings (meals, transportation, social/recreational activities)? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

<ul style="list-style-type: none"> Do members have access to such things as a television, radio, and leisure activities that interest them and can they schedule such activities as desired? 	
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>h) Do members have access to food at any time and do they choose when, what, where, and with whom to eat as applicable to the setting?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Does the setting afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or mealtimes? Does the setting provide for an alternative meal and/or private dining if requested by the individual? Are members made to eat with housemates, neighbors, or as a group? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>i) Are members employed or active in the community outside of the HCBS setting?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>j) Do members have opportunities to pursue competitive, community employment as desired?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
<p>k) Do members have access to the community to the same degree as their non-disabled peers in the general community?</p> <p>THINGS TO CONSIDER:</p> <ul style="list-style-type: none"> Do members access (as desired and applicable) essential and non-essential shopping, recreation, restaurants, religious services, exercise, healthcare, personal grooming services, and visits with family and friends? 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
l) Are member's rights to privacy, dignity and respect protected? THINGS TO CONSIDER: <ul style="list-style-type: none"> Do staff knock and wait to enter members' private spaces. Do members dress in their own clothes appropriate to the time of day, weather, and individual preferences? Do staff address members and communicate with members in a dignified manner? Are members made to wear bibs at mealtimes? Are individuals treated age-appropriately? Is personal assistance provided in private? Is informal communication conducted in a language that the member understands?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
m) Are members free from coercion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
n) Are members free from restraint?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	
o) Are limitations, modifications or restrictions made to settings requirements and/or rights afforded due process at the individual level?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Explain:	
If the setting is not in compliance with the standard, describe plan to meet the standard(s) or describe the reason you are not required to meet the standard(s):	

Attachment G

PACKAGE OF EVIDENCE SUMMARY

ORGANIZATION AND SETTING DETAILS

Insert photo of site if appropriate.

Organization Name:
Phone:

Setting Name:	
Street address of setting:	Date of site review:

FUNDING AND SERVICES IN THIS SETTING

Mark all funding sources and services provided in this setting.

HCBS Waiver/Habilitation	Service(s)
<input type="checkbox"/> AIDS/HIV Waiver <input type="checkbox"/> Brain Injury Waiver <input type="checkbox"/> Children’s Mental Health Waiver <input type="checkbox"/> Elderly Waiver <input type="checkbox"/> Health and Disability Waiver <input type="checkbox"/> Intellectual Disability Waiver <input type="checkbox"/> Physical Disability Waiver <input type="checkbox"/> Habilitation <input type="checkbox"/> Money Follows-the-Person (MFP) <input type="checkbox"/> Other:	<input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assisted Living Service <input type="checkbox"/> CDAC Agency <input type="checkbox"/> Day Habilitation <input type="checkbox"/> Home Based Habilitation <input type="checkbox"/> Prevocational services <input type="checkbox"/> Supported Community Living (SCL) <input type="checkbox"/> Residential-Based SCL for children (RBSCCL) <input type="checkbox"/> Supported Employment <input type="checkbox"/> Intensive Residential Service (IRS) <input type="checkbox"/> Other:

ADDITIONAL DETAILS

List the number of HCBS funded members and non-HCBS funded members served in this setting.	HCBS funded: Non-HCBS funded:
Is this setting provider owned or controlled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this setting an existing location or a new or prospective location?	<input type="checkbox"/> Prospective <input type="checkbox"/> Existing <input type="checkbox"/> New (<input type="checkbox"/> Check this box if the location is a newly constructed facility.)

<p>What category of heightened scrutiny applies to this setting?</p>	<p><input type="checkbox"/> NA</p> <p><input type="checkbox"/> Category 1: Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment</p> <p><input type="checkbox"/> Category 2: In a building on the grounds of, or immediately adjacent to a public institution</p> <p><input type="checkbox"/> Category 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS</p>
<p>What subcategories apply to this setting (select all that apply).</p>	<p><input type="checkbox"/> HCBS in ALF that are physically attached to a NF</p> <p><input type="checkbox"/> HCBS in larger than 3-5 bed RCF</p> <p><input type="checkbox"/> HCBS (such as ADC, DH, employment services) in an RCF, NF, hospital, or other facility</p> <p><input type="checkbox"/> Setting limits individuals' opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS due to the design or model of service provision.</p> <p><input type="checkbox"/> Setting restricts members' choices to receive services or to engage in activities outside of the setting.</p> <p><input type="checkbox"/> Setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services.</p> <p><input type="checkbox"/> Clusters of sites including several units with people receiving HCBS in a multi-plex of any kind, clusters within neighborhoods, streets, communities, etc. that are clustered together by design for the purpose of receiving HCBS.</p> <p><input type="checkbox"/> Newly constructed or newly licensed facility</p> <p><input type="checkbox"/> Site is/was a facility converted to HCBS</p> <p><input type="checkbox"/> Quality of care concern related to HCBS settings requirements</p> <p><input type="checkbox"/> Site-based employment service such as a "sheltered workshop"</p> <p><input type="checkbox"/> Other:</p>

EXPLANATION

Home and Community-Based Services (HCBS), whether residential or nonresidential, must be provided in integrated, community-based settings that support members' full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS. HCBS services are required to be provided in such a way as to optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact. If an individual requires a restriction or limitation in one or more of the areas listed below, due process of that restriction or

limitation should be outlined in their person-centered plan. Policies and procedures related to restrictive interventions should be followed.

DESCRIPTION OF SETTING

These are instructions. Please remove before posting.
 Please provide a general description of the setting and the reason for the setting assessment. The description should include but is not limited to the following.

- A description of the location within the community.
 - o Describe the surrounding community, neighborhood, and neighbors.
 - o Describe any other offices, businesses, or services provided at the same location.
 - o Describe the proximity to community resources such as public transportation, recreation, cultural and religious activities, and shopping.
 - o For sites that have been remodeled or newly constructed, explain what modifications have been made and how the renovations/construction ensures HCBS settings requirements are met.
- A description of the physical characteristics of the site.
 - o Describe the floorplan, the number of bedrooms, and available common areas.
 - o Explain if the residential site is a single-family home or a unit or units in a multiplex or something else.
 - o For non-residential sites, explain access to the site by the general community.
 - o Describe the entrances and exits and any distinction between the those used by members, staff, and the general community.
 - o Explain how there is a meaningful distinction between HCBS services and institutional care that is or was provided in/ adjacent to/attached to the same location or in combination with institutional care.
 - o Explain how the location is accessible to the members served there.

A description of any physical characteristics of the location or physical building that supports or fails to support HCBS settings requirements.

SETTING ASSESSMENT SUMMARY

Did the organization attest to being compliant with HCBS settings requirements in the same or similar settings on their most recent Provider Quality Self-Assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No: EXPLAIN
Does the organization operate other HCBS sites that have been determined through their most recent Quality Oversight Review to be compliant with HCBS settings requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No: EXPLAIN
These are instructions. Please remove before posting. Explain the reason for the settings assessment and a summary of findings after assessing the setting. The description should include but is not limited to the following.	

- Highlights from quality oversight reviews, residential assessments, the annual self-assessment, and/or a settings assessment that support or do not support the organization's compliance with HCBS settings requirements.
- Establish the organization's/setting's ability or inability to overcome institutional presumptions and to demonstrate a meaningful distinction between institutional settings and HCBS.
- Establish the organization's/setting's ability or inability to overcome the effect of isolating individuals receiving Medicaid HCBS from the broader community.
- Describe what has been done to ensure members have a non-institutional experience in the newly established HCBS setting.
- Explain what has been implemented to prepare staff for providing HCBS services, especially if the staff are transitioning from an institutional setting to an HCBS setting.
- Explain whether other quality oversight activities (i.e. the most recent self-assessment, the most recent onsite or related desk review, applicable residential assessments, etc.) with the organization support or do not support observations from onsite tours, interviews and information from the organization about this setting, and findings from this settings assessment. If the organization has been required to take corrective action related to HCBS settings requirements in the past, explain the issue and how they were able to achieve compliance.

COMPLIANCE DECISION

Name and title of person who completed this package of evidence summary:	
<p>Compliance Status and Recommendations</p> <p><input type="checkbox"/> Evidence supports that the setting is compliant with HCBS settings requirements. Organization is required to maintain ongoing compliance with all HCBS requirements.</p> <p><input type="checkbox"/> Evidence supports that the setting is NOT compliant with HCBS settings requirements.</p> <p style="margin-left: 20px;"><input type="checkbox"/> Setting could/did meet requirements for HCBS Settings with remediation.</p> <p style="margin-left: 40px;">o Date remediation plan (CAP) accepted:</p> <p style="margin-left: 40px;">o Date remediation (CAP and compliance) achieved:</p> <p><input type="checkbox"/> Setting is unable or unwilling to meet requirements by compliance deadline.</p> <p><input type="checkbox"/> Other:</p> <p>Next Steps</p> <p><input type="checkbox"/> Post for public feedback (<i>HCBS Specialist to complete a package of evidence summary.</i>)</p> <p><input type="checkbox"/> Refer to CMS further heightened scrutiny review</p>	

Attachment H

GLOSSARY OF ABBREVIATIONS

Abbreviation	Definition
ACT	Address Collection Tool
ADC	Adult Day Care
AIDS/HIV	AIDS/HIV Waiver
ALF	Assisted Living Facility
BI	Brain Injury (Waiver)
CAP	Corrective Action Plan
CMHW	Children's Mental Health Waiver
CMS	Centers for Medicare and Medicaid Services
DH	Day Habilitation
EW	Elderly Waiver
HBH	Home-Based Habilitation
HCB	Home and Community Based
HCBS	Home and Community Based Services
HD	Health and Disability Waiver
IAC	Iowa Administrative Code
CFR	Code of Federal Regulations
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disability
ID	Intellectual Disability Waiver
IMD	Institutions for Mental Disease
IME	Iowa Medicaid Enterprises (now known as Iowa Medicaid)
IMPA	Iowa Medicaid's Portal Access
IPES	Iowa's Participant Experience Survey
MCO	Managed Care Organization
PD	Physical Disability (Waiver)
PHE	Public Health Emergency
PV	Prevocational Services
QIO	Quality Improvement Organization
RBSCCL	Residential Based Supported Community Living
RCF	Residential Care Facility
SA	Self-Assessment
SCL	Supported Community Living
SE	Supported Employment
SFY	State Fiscal Year

Attachment I

SAMPLE VALIDATION CHART

Assessment Results	Residential Service Settings					Non-Residential Service Settings			
	Supported Community Living Service Settings	Home Based Habilitation Service Settings	Residential-Based Supported Community Living Service Settings	Assisted Living Service Settings	CDAC Agency Services provided in an RCF or ALF Setting	Adult Day Care Service Settings	Day Habilitation Service Settings	Prevocation al Service Settings	Supported Employment Service Settings
Total Number of Settings									
Number of Settings Assessed									
Complied Without Modifications									
Complied With Modifications									
Unwilling or Unable to Comply									
Disenrolled/Discontinued Services									
Number of Settings Requiring Heightened Scrutiny Review									

Attachment J

PROMULGATED RULES

HUMAN SERVICES DEPARTMENT [441]

Notice of Intended Action

ARC 3784C

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

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

Legal Authority for Rule Making

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

State or Federal Law Implemented

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

Purpose and Summary

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

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

Fiscal Impact

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

Jobs Impact

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

Waivers

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

Public Comment

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

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

Public Hearing

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

Review by Administrative Rules Review Committee

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

The following rule-making actions are proposed:

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

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following

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

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

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

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

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

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

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

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

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

and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ITEM 14. Amend paragraph **78.27(4)“a”** as follows:

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

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

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

(3) to (8) No change.

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

(10) No change.

ITEM 15. Amend paragraph **78.27(8)“b”** as follows:

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

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

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022,

payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal

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

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

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

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

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

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

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the

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

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

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

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

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

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.

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

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

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

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

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

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4).

The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

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

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

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

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

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

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

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4).

The member service plan or treatment plan shall include documentation of:

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

- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction. ITEM 30. Amend rule 441—78.43(249A), introductory paragraph, as follows:

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

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

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

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

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

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

- (1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction. ITEM 34. Amend rule 441—78.46(249A), introductory paragraph, as follows:

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

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

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

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

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction. ITEM 37. Amend rule 441—78.52(249A), introductory paragraph, as follows:

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

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

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

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4).

The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

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

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

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

“Service plan” means a written consumer-centered person-centered, outcome-based plan of services developed using an interdisciplinary process, which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. It may involve more than one provider. The service plan is developed by

the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

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

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

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

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

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

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

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

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

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

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

representative, member's family, service providers, and others directly involved with the member.

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