

CMS requires that states to be in full compliance with the setting regulations by March 17, 2023. In preparation of the March compliance date, CMS is requiring that all states submit responses to the following questions by January 1, 2023.

1. Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations.

The following actions have been taken by the state to embed the HCBS regulatory criteria into the initial, continuous, and ongoing oversight of residential and non-residential settings where Home and Community Based Services (HCBS) waiver and State Plan Habilitation services are provided. Changes included updates to Iowa Administrative Code (IAC) HCBS waiver and Habilitation rules, corresponding provider manuals, changes to quality oversight and certification standards, and the addition of an HCBS settings monitoring tool used by case managers to assess every member's residential HCBS setting for compliance with the Final Rule.

HCBS Waiver and Habilitation Rule Changes

Administrative rules to implement the settings requirements were effective August 1, 2018. Changes were made to Iowa Administrative Code (IAC) 441-Chapters 77, 78, and 83. The administrative rules require all HCBS waiver and Habilitation members to receive residential and non-residential services in integrated community-based settings and sets parameters for all settings including provider owned and controlled settings. HCBS providers are required to provide services in such settings. The HCBS Quality Improvement Organization (QIO) and Case Manager monitor services for compliance with settings. The rules require the department to establish initial and ongoing quality assurance activities for compliance with the regulations.

Manual Updates

Provider manual updates are conducted as part of the rule making process and as needed. Manuals were therefore updated when IAC changes were made.

Quality Oversight Processes

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. Most quality oversight processes existed prior to the implementation of the HCBS setting rule, but may have been leveraged, expanded, or enhanced to assist in determining compliance with

HCBS settings requirements. All four main review types were updated to include oversight of HCBS settings criteria into ongoing operations.

Provider Quality Self-Assessment Include Settings Requirements

In the early 2000's, Iowa Medicaid implemented an annual Provider Quality Self-Assessment to enhance the regular, ongoing review of providers. The HCBS Provider Quality Self-Assessment (SA) tool (form #470-4547) 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), IAC, and other standards and best practices.

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 HCBS was provided. In 2018, the settings requirement section was refined to separate requirements for provider owned and controlled residential settings from general settings requirements.

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."

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 and controlled residential settings from general settings requirements.

Residential Assessment

The Residential Assessment 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.

The Residential Assessment Tool is currently undergoing an update to ensure the tool, 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.

Waiver Application in the Waiver Management System

The state has included assurances within the waiver application in the Waiver Management System (WMS). The state assures that all HCBS waiver applications, renewals and amendments will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan (STP). The state will implement any CMS required changes by the end of the transition period as outlined in the STP.

2. *Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.*

The state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance with the HCBS Settings Final Rule through the provider application process, ongoing quality oversight reviews, and Residential Assessments.

Initial Enrollment and Addition of Services or Settings

The QIO HCBS Unit reviews new HCBS waiver and Habilitation providers and settings when:

- 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).

The enrollment review assures new providers and settings comply with the setting rules prior to funding HCBS in the setting. A new provider may not bill for services until they are enrolled with Iowa Medicaid. New providers complete the HCBS Provider Quality Self-Assessment and receive QIO HCBS Unit approval prior to receiving HCBS funding. Any new setting identified as meeting criteria in categories 1, 2 or 3 of heightened scrutiny require QIO HCBS Unit approval prior to HCBS funding in the setting and may require a heightened scrutiny review and CMS approval.

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.

Once a provider is enrolled and approved to provide HCBS services, the QIO HCBS unit will provide ongoing provider oversight through the provider quality oversight reviews.

Ongoing Quality Oversight Review

Non-residential HCBS settings will be assessed on a five-year cycle. The quality oversight 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.

Residential Assessment

Residential HCBS settings are monitored for continued compliance through the Residential Assessment Process. The Residential Assessments are required to be completed annually so residential HCBS settings are reviewed on a one-year cycle.

- 3. Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.**

There are multiple ways in which a member, guardian or family member may notify the state of provider non-compliance with the HCBS setting regulations, including the following.

Notifying the QIO HCBS Unit

Members, guardians, and advocates may contact the QIO HCBS Unit directly with complaints or concerns about provider compliance with HCBS setting regulations. Avenues of communication include:

QIO HCBS unit email address: HCBSWaiver@dhs.state.ia.us

HCBS Setting email address: HCBSsettings@dhs.state.ia.us

Residential Assessment Process

Residential Assessment results are another way the state may be alerted of provider non-compliance with the HCBS setting regulations. Through the administration of the assessment tool, case managers open the conversation and give members the opportunity to express their experiences living an HCBS setting. The Residential Assessment specifically seeks to understand if the member's residential HCBS setting ensures the following standards.

The nine-member personal outcomes include:

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

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

questions as the outcome is defined by the member as it applies to their life in the community and identifies the experience of the member living in their residential setting.

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

Section IV. "The Bottom Line" of the residential assessment asks the case manager to answer three questions to summarize the outcome of the interview with the member. The three outcomes help determine if the member has access to and uses the resources of the community in which they live to the degree desired by the member. The three questions/outcomes are:

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

The Residential Assessment tool is in the process of being updated to allow for better data collection and an enhanced remediation process if the setting does not comply.

The Iowa Participant Experience Survey

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.

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:

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

Immediate concerns found through the IPES 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 30 days. The explanation or remediation plan is reviewed by a QIO HCBS Specialist to ensure the “flagged” concerns have been appropriately resolved. The QIO HCBS Specialist will work with the case manager until the “flagged” issue is remediated appropriately. 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 issues in a specific setting.

Townhall Meetings

Iowa Medicaid has regular monthly Townhall Meetings for member, guardians, family, and advocates. There is a set agenda for the Townhall Meetings, but each offers opportunity for members to address concerns about Medicaid and HCBS waiver and Habilitation services.

Public Notice During Heightened Scrutiny

All residential and non-residential settings that rise to a level of heightened scrutiny receive a review and subsequent findings report on the state's findings. The reports are posted to a dedicated HCBS Settings webpage for public consumption. Reports are posted for public comment for 30 days during which all have opportunity to comment on specific settings.

Case Manager Oversight

Case managers are required to have collateral contacts with each member monthly and meet the member in their home at least quarterly. As noted above, the case manager conducts a Residential Assessment at least annually with the members to assess how the members setting is meeting their community integration needs. Each of the regular contacts with a member's case manager is an opportunity to receive feedback on any issue that a member has regarding the residential and non-residential settings where services are provided.

Provider Appeals and Grievances

Providers are required by rule to have a formal appeal and grievance process in place to assure that members, guardians, families, and advocates have opportunity to voice complaints and request reconsiderations to applied policies and procedures. This includes any issue with the implementation of settings rules and regulations. To assure that all providers have a process in place, the QIO HCBS Unit validates that a policy and procedure has been established through the annual Provider Quality Self-Assessment process and through the ongoing quality oversight review processes as identified above.