



2014 HCBS Provider Self-Assessment Frequently Asked Questions

Introduction: Comments are grouped by topic, and within each section comments of a similar nature may be grouped together with a single response provided for each group. Comments from a single person that covered multiple issues may have been divided into topics as noted above; however, written comments are included verbatim, comments received in-person have been paraphrased based on notes taken by department staff present at the trainings.

Question: When will we have the FAQ?

Answer: Once training has been completed and all questions have been addressed, the FAQ will be posted to the website. We anticipate that process will take at least a week to complete after the last training has been completed. FAQ will be emailed to all training participants, and the training webinar has been posted on the DHS website at

<http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment>.

Section 1: Questions related to completion of Section C-2, service location sites.

Please note, instructions for completion of Section C-2 have been revised. Please complete this section for all sites considered to be provider owned or provider controlled.

1. **Question:** Can we take the information off the site location (C-2) and put it on a spreadsheet?

Answer: Data for this section may be submitted in the form of a spreadsheet. If a provider decides to submit information for this section in spreadsheet format, they must ensure all fields contained on the form are included in the spreadsheet, and submit the spreadsheet with the remainder of the self-assessment. Once the spreadsheet has been received and approved by the HCBS Specialist, the Specialist may request an emailed version of your spreadsheet. Do not submit the emailed version until it has been requested by your Specialist.

2. **Question:** Do we need to gather hourly SCL and CDAC site locations?
3. **Question:** We provide Supported Employment in the community, do we include those sites?
4. **Question:** Does this include 24-hour sites, are they all daily rate members, those that are in day programming, do these still need to be included in this sections as provider controlled?
5. **Question:** Should the day habilitation site be included as it is provider-controlled?
6. **Question:** Site locations provider-controlled site? Market place that is a training site-- Would this be a provider-controlled site?
7. **Question:** Are Habilitation and vocational programs that meet at a central location for pick up and drop off considered provider owned or controlled?

Answer to questions 2-7: Examples of sites that need to be included in C-2 Site Location:

- Hourly services if they are occur in a provider owned or provider controlled setting.

- Day Habilitation, Adult Day Care and Pre-Vocational (if services are provided in a sheltered workshop type setting) programs are considered provider owned/provider controlled.
- Sites where services are provided 24 hours per day. A marketplace training site may be considered provider controlled if the provider owns, controls, or arranges for the site to be available as a training site.
- A centralized location for pick up or drop off does not apply to this section as we are collecting information relative to the site of service provision

8. Question: Would it be accurate to state the site is member owned if owned by the member and staff providing services are provider controlled?

Answer: This is correct, however the provider must consider the degree to which staff has control over the setting. For example, if staff is present seven hours per day, and the site contains signage instructing activities to be performed, or a message board posted for staffing needs, this may be considered provider controlled.

9. Question: Who would be the contact person that needs to be identified in the site location section?

Answer: If there is not a designated contact person for the service provision site, indicate the staff that is responsible for direct care staff, for example the site coordinator or supervisor.

10. Question: What "with five or more members" actually means in the last box?

Answer: The field "for sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services" pertains to the Iowa Administrative Code regulation stipulating HCBS cannot be provided in sites containing more than four members without Department approval (IAC 78.41(1)c and 78.43(2)c). For each site that contains five or more members, the provider should have either licensed the site or contacted Department of Human Services for approval.

11. Question: Adult day care – do we provide the number of people who receive services in that location/setting? Do we count waiver and non-waiver members in this number?

Answer: The response for this section must include all persons receiving service at the site location. If services are provided to both waiver and non-waiver members, both populations would be included in the response. One method to demonstrate integration of the site location would be to include a note indicating the number of waiver and non-waiver members.

12. Question: If I have a site that is not provider-owned and the member receives services out in the community, do I need to include that site on the list of site locations?

Answer: The primary site in which the member lives or receives services is the site required to be listed. You do not need to list service location sites where the member travels in the community, such as a visit to the grocery store, for example.

Section 2: Questions related to HCBS Settings Rules, and how those rules pertain to Iowa's HCBS providers.

- 1. Question:** When can we expect clarification on the setting information?
Answer: CMS has indicated to states there will not be further clarification provided regarding settings information. HCBS Settings Rules 42 CFR 441.301(c)(4) and 42 CFR 441.710(a) went into effect March 17, 2014 and pertain to all providers receiving federal HCBS funds.
- 2. Question:** Providers needing clarification on Provider Controlled, are hesitant because the word “controlled” sounds so strong.
Answer: In the guidance provided with the Settings Rules, CMS identified that a "setting is considered provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS", and the state of Iowa determined to use the same standard.
- 3. Question:** We don't know how to answer Section E – Guarantee of Accuracy. It asks “Does your organization attest to being compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a) or have a plan to come into compliance with this rule prior to March 17, 2019. I assume providers are supposed to answer both of these questions the same? How can we answer these without knowing the settings definitions that we have been waiting for CMS to release for community settings services? If we answer no, we need a plan to be compliant but how do we develop a plan without knowing what is considered to be non-compliant/compliant?
Answer: As the HCBS Settings Rules went into effect March 17, 2014 providers need to answer the self-assessment questions pertaining to the rule based on the provider's current assessment of compliance with the rules. It is anticipated a large number of providers will require self-identified corrective action plans in order to come into compliance with the Settings Rule.
- 4. Question:** Habilitation providers were asking about their home-based habilitation services, do these need to comply with settings rule? Also do county-funded services/members need to be included in the settings?
Answer: All HCBS services that receive federal funding need to comply with the HCBS Settings Rule. County funded sites are not addressed in the Settings Rules, however providers with county funded sites are required to meet Olmstead regulations, as well as those of any other licensing or accrediting body to which they are accountable.

Section 3: Questions related to completion of Section D, Service Plans.

- 1. Question:** Clarify which CFR references apply to person-centered service plans and which ones apply to settings transition?
Answer: CMS reference for HCBS Settings Rules is 42 CFR 441.301(c)(4) and 42 CFR 441.710(a), reference for person-centered service planning is 42 CFR 441.725.

- 2. Question:** Service plans, section #1a determining if the setting is integrated? How do we prove that? Does it need to specifically state that it's integrated?

Answer: Community Integration can be demonstrated in many ways. Providers are encouraged to use the Exploratory Questions for Assessment of Home and Community-Based Services (HCBS) Residential Services" document available on the DHS website at <http://dhs.iowa.gov/ime/about/initiatives/HCBS> to evaluate integration of site locations and documentation in service plans. The Department and HCBS QA activities will be using case manager's service plans, functional assessments, social histories, and provider service plans as evidence of member choice and integration into the community.
- 3. Question:** What about access to the community in rural areas? If the member wants access to transportation are they limited because they are so far from community centers? Are we limiting access to communities if it's cost prohibitive?

Answer: Service plans and documentation demonstrating integration would be expected to reflect access to community locations in a similar manner as access to community locations individuals without a disability would experience. The Settings regulations do not require that opportunities for people receiving Medicaid HCBS go beyond what is available for persons not receiving HCBS; only that individuals receiving HCBS have access to the same opportunities. Member choice in residing in a rural versus a metropolitan area should be considered and discussed during the service planning process.
- 4. Question:** What is accepted as evidence for requirement C-item B "all available settings"?

Answer: The Case Manager's service plan should include documentation that the member chose the services that they are receiving. As indicated above, it is anticipated the provider will have an assortment of documents to support member choice.
- 5. Question:** In C-1-F, Rights Restrictions-What kind of evidence are you looking for to show that there has been informed consent of the restriction to member and or representative?

Answer: We will review the Case Manager's and provider's service plans as well as other documentation to demonstrate that the member was included in determining restrictions and agrees to the implementation of restrictions.
- 6. Question:** When looking at C-1 b and e in SA, sometimes providers have no control over case manager plans?

Answer: This question may be addressing several issues. The provider should be an active participant in the interdisciplinary team (IDT) meeting, and is expected to be able to demonstrate efforts to obtain the Case Manager's service plan if the provider has not received it. If the provider has participated in the IDT, and does not believe the case

manager's plan accurately reflects what the IDT agreed upon, it is expected the provider will discuss the differences with the Case Manager, and document those discussions.

- 7. Question:** Previously, we were directed to contact the HCBS Specialist should the provider have a difficult time getting the case management service plan. I made the assumption, should this be the same process when the provider has a difficult time getting a Habilitation service plan from an IHH care coordinator?
Answer: Document the attempts to obtain the service plan, and then contact your HCBS Specialist if you are unsuccessful in obtaining the service plan from either entity.
- 8. Question:** Social histories are not required by providers?
Answer: The provider will be expected to provide evidence that they have asked for the social history from case managers.
- 9. Question:** For an Assisted Living setting that has a CM service plan that addresses the provider-owned requirements--Does this need to be in the member service plan?
Answer: The response for this question assumes the Assisted Living is enrolled for Consumer Directed Attendant Care (CDAC). The Assisted Living will have both the Case Manager's service plan and the CDAC agreement to document evidence of meeting provider owned requirements.
- 10. Question:** Will you be providing service plan training?
Answer: HCBS will be presenting a webinar at a future date with further details regarding service plan training.

Section 4: Questions related to contracts with members.

- 1. Question:** On page 14 regarding contracts with members, the landlord has a lease contract with the members. If it's an involuntary discharge does the service agreement need to address that it's also a discharge from the residence? What happens in an emergency discharge? Does not mean they are immediately discharged from their residence?
Answer: With member owned or controlled housing, service contracts with members are separate from lease agreements. Providers are expected to have clear policy and procedures relative to contracts/agreements. The policy and procedures must clearly identify if service provision is directly related to the setting in which the lease is signed. If an individual resides in a setting that is not provider owned, he/she may have the right to bring in another agency to provide services.
- 2. Question:** For assisted living providers that are not required to have a service contract, is "NA" an appropriate response?
Answer: If the services your agency is enrolled for do not require member contracts by Iowa Administrative Code (IAC), Iowa Code or Code of Federal Regulations (CFR), you

can answer "NA". However, please note questions 1-4 of this section pertain to contracts with members who receive services in provider owned or provider controlled settings.

Section 5: Questions related to Section F - Direct Support Professional Workforce Data Collection.

This section was initially created by the Department to identify the total number of staff that would require mandatory training, at a time when more extensive mandatory training was proposed. November 27, 2012 Informational Letter 1188 explained this requirement "IME is requesting information from providers to collect data on the workforce providing waiver services in cooperation with the Iowa Department of Public Health and the Iowa Direct Care Worker Advisory Council. The data collected from the Direct Care Workforce Data Collection component of the self-assessment is required to fulfill a request by the Iowa General Assembly related to the size and composition of the direct care workforce". Data in this section demonstrated the significant efforts that would have been required to implement the training that was proposed that that time, and continues to show the significant effort that would be required if such training requirements would be implemented in the future.

1. **Question:** What do you do with the Section F demographics information?
Answer: This information is gathered and used to respond to requests for information from various entities, in addition to the purpose identified above.

2. **Question:** When answering the question about total number of full-time and part-time employees would you include all staff?
Answer: Yes, this includes all staff paid by your organization including contract staff.

3. **Question:** When this is filled out, do we need to go back and look at how many staff we have employed over a certain period of time?
Answer: No, this is a snapshot of employment on the date the self-assessment is filled out.

4. **Question:** Does Section F demographics question 2 include habilitation service providers?
Answer: As Habilitation services are not listed in the "Individuals providing the following waiver services", they would not be included in the response to question 2.

5. **Question:** Section F regarding FT/PT, does FT pertain only to staff that work FT (full time) hours under HCBS? For example, we have a Home Health Aide who provides 20 hours of service to HCBS clients and 20 hours of service to private pay/insurance clients, would this be considered a FT or PT employee?
Answer: If your organization classifies an employee as full-time, the employee is included in the full time demographic, and vice versa for part time employees, regardless of the payment source utilized by the person receiving services.

Section 6: Miscellaneous topics.

1. **Question:** If an Assisted Living is not enrolled for any service other than On-Call, is a self-assessment required?

Answer: All services included in Section B that a provider is enrolled for require submission of an annual Provider Self-Assessment. If the service is not listed, no self-assessment is required. On-Call service is not included in Section B and therefore does not require a self-assessment if the provider is not enrolled for other services that would require a self-assessment.

2. **Question:** Is there a fax number posted?

Answer: Directions for completing and submitting the self-assessment are on page 1 of the self-assessment. These directions include both the mailing address and fax number to be used for submission.

3. **Question:** Section E--If we earned less than a 3-year accreditation/certification, do we send that in?

Answer: Yes. If your organization received less than the maximum level of accreditation or length of licensure, your review results and corrective action plan submitted to the accrediting or licensing body must be submitted to HCBS with your self-assessment.

4. **Question:** Is current Iowa Code in compliance with CFR?

Answer: Neither Iowa Code or Iowa Administrative Code have been updated to include all standards from CMS HCBS Settings Rule or Person-Centered Planning Rules. The Person Centered Planning rule was effective March 17, 2014, and the HCBS Settings Rules became effective on the same date. Federal requirements are required to be met in order to receive federal funds whether state rules and regulations have been updated. The department is in the process of drafting rule changes related to both of these federal requirements.

5. **Question:** In Section A we list the main office, do we list it again in C-1?

Answer: Yes, all office locations are required to be listed in Section C-1.

6. **Question:** Is a faxed "no follow-up" document required?

Answer: The intent of the question is unclear; however retention of the provider's fax confirmation page documenting the successful fax transmission of the self-assessment is best practice. Once a provider's HCBS Specialist has received, completed review, and approved the self-assessment, a letter will be mailed to the agency.

7. **Question:** If the provider has some areas that meet the Federal guidelines and some not, how should we answer the areas?

Answer: Each question should be completed according to the agency practice. It is reasonable to expect some questions will have a "No" response and some may have a

"Yes" response. If any areas contain a "No" response, the provider is required to identify a self-corrective action plan that will enable the provider to become compliant with the HCBS Settings Rule by March 17, 2019. Compliance for self-identified corrective action plans will be assessed through annual Provider Self-Assessments and regularly scheduled HCBS review activity.

- 8. Question:** What is the timeframe for HCBS to review for errors on Self-Assessment and respond to Agency for corrections?

Answer: Once a fully completed Provider Self-Assessment has been received, the HCBS Specialist has two business days to review.

- 9. Question:** Question on IMPA--Habilitation providers do not submit incidents through IMPA any longer, so how should we respond to the question about submitting incident reports through IMPA.

Answer: If the provider is only enrolled through Magellan to provide Habilitation services, the provider would respond "No" and complete the comment section to indicate their incident reports are submitted to Magellan. No corrective action would be required in this scenario.

- 10. Question:** What sections apply to Elderly Waiver Case Management in regards to the HCBS settings?

Answer: All providers should review the self-assessment and determine which areas are required for services they are enrolled to provide. In response to this particular question, Case Managers are responsible for standards identified in Service Plans, question 2 (Person-Centered Planning rule 42 CFR 441.725).

- 11. Question:** Does a court committal exempt the need for Section D III requirement 1?

Answer: The Intake and Admission process should be evident for those providers for whom their enrolled services require the process. If a member is court committed to the provider for services and/or residence, this should be documented in the member file according to the agency's process. Service coordination including access and coordination of supports should be documented regardless of how the member presents to the agency for services.

- 12. Question:** Are we doing Quality Assurance reviews on Habilitation only providers?

Answer: Quality Assurance reviews are completed for all providers who are enrolled for any service listed in Section B, including habilitation providers.

- 13. Question:** Explain how I answer "No" versus "NA" on self-assessment?

Answer: A "No" response indicates the provider does not currently have policies, practices and documented evidence in place, and the services the provider is enrolled for require the standard according to Iowa Administrative Code (IAC), Iowa Code, or Code of Federal Regulations.

An "NA" response indicates the provider does not currently have a policy, process or

documented evidence of implementation of the standard, and the services the provider is enrolled for do not require the standard according to IAC, Iowa Code, or Code of Federal Regulations.

14. Question: How do I address the question Abuse....and/or.....?

Answer: This question was received in the following format "Abuse...and/or...please complete correctly". The response for this answer is based on the assumption the question is addressing Section D, Training Requirements regarding child and/or abuse training. This is an Iowa Code requirement and pertains to all providers. If a "No" response is selected, the provider must self-identify a corrective action plan to bring this standard into compliance.

15. Question: How do we provide evidence that we are enrolled in IMPA?

Answer: This may be demonstrated either by a screen shot from an IMPA incident report, showing Specialist their log in during an onsite review or by having multiple incident reports filed through IMPA.

16. Question: We have several habilitation homes that are five bed homes and have talked to (DHS) on the 5-bed homes and was advised we did not need an exception to policy as that only applied for ID/BI and not Habilitation. So if that is the case, as the response options are to choose if the site is licensed by DIA or approved by DHS, what would the correct response be? If we feel the correct response is not either choice, then do we need to put a response regarding this on a document?

Answer: Iowa Code requires that any institution, place building or agency providing for 24 consecutive hours of services to three or more individuals to be licensed unless they are exempt from licensing according to 135C (1) (19) and then department approval is required for any site serving five individuals. An exception to policy is not needed for 5-person sites regardless of whether ID, BI, or Habilitation members are served there; however, approval by the Department is required for all ID, BI, or Habilitation 5-person sites. Once the Department approves a site written notice is given to the provider. The provider is responsible for retention of that written notice as evidence of approval. If the provider has written notice of approval or licensure with DIA, the response is yes. If the provider does not have either, the response is no.

17. Question: How do I get a legal name and change of address form for IMPA, I cannot get one from the website?

Answer: This form may be requested by calling Provider Services at 800-338-7909.