# Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information

A. The **State of Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
**Home and Community Based Services Elderly Waiver**

C. **Waiver Number:IA.4155**
**Original Base Waiver Number: IA.4155.**

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
08/01/13
**Approved Effective Date of Waiver being Amended: 08/01/13**

## 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:
Multiple purposes:
* To add Assisted Living Service, which was approved by CMS on 11/17/14, effective 3/1/13.
* Increase the number of members served at one time to 9500.
* Include Iowa's plan to become compliant with the Settings Rules
* To include corrections to HCBS waiver applications as directed by CMS staff for the Intellectual Disability waiver renewal currently in process.
* to include transition to a Core Standardized Assessment during 2015, in accordance with the BIP grant.

## 3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☑ Waiver Application | 7, attachmen |
| ☐ Appendix A – Waiver Administration and Operation | |
| ☑ Appendix B – Participant Access and Eligibility | 3, 4 |
| ☑ Appendix C – Participant Services | 1, 3, 4, 5 |
| ☑ Appendix D – Participant Centered Service Planning and Delivery | 1 |
| ☑ Appendix E – Participant Direction of Services | 1, |
| ☐ Appendix F – Participant Rights | |
| ☑ Appendix G – Participant Safeguards | 2 |
| ☐ Appendix H | |
| ☑ Appendix I – Financial Accountability | 3 |
| ☑ Appendix J – Cost-Neutrality Demonstration | 2 |

B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

- [x] **Add/delete services**
- [x] **Revise service specifications**
- [x] **Revise provider qualifications**
- [x] **Increase/decrease number of participants**
- [ ] **Revise cost neutrality demonstration**
- [x] **Add participant-direction of services**
- [ ] **Other**

Specify:

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A.** The **State** of **Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Home and Community Based Services Elderly Waiver**

**C. Type of Request: amendment**

**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: IA.4155**
**Draft ID: IA.006.05.01**

**D. Type of Waiver** *(select only one):*
Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 08/01/13**
**Approved Effective Date of Waiver being Amended: 08/01/13**

## 1. Request Information (2 of 3)

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- [ ] **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [x] **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goal of this waiver is to provide community alternatives to institutional services. Through need based funding of individualized supports, eligible members may maintain their position within their homes and communities rather than default placement within an institutional setting.

The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid. Individuals access the Elderly Waiver services by applying at their local DHS office with their

income maintenance worker. If the member is deemed eligible and a slot on the waiver is available, the member will be assigned a case manager for service coordination. If the member is not able to immediately access a waiver slot, the member's worker requests that the member be placed on a wait list until a slot becomes available. Each member applying for waiver services must meet nursing facility or skilled nursing facility level of care. With the input of the case manager, medical professional, and other appropriate professionals, the level of care determination is made by the IME's Medical Services unit. Once the level of care is determined and the member's application is approved, the member is approved to receive waiver services. The case manager then works with the member, interdiscipplinary team, and others of the member's choosing, to develop a service plan consistent with the assessed medical needs of the waiver member.

The services that are considered necessary and appropriate for the member will be determined through a person centered planning process with assistance from an interdisciplinary team consisting of the member, case manager, service providers, and others the member chooses. After exploring all available resources, including natural and community supports, the member will have the option to choose between a variety of traditionally delivered and self-directed services funded by the Elderly Waiver.

The individual will select the option to use both traditional delivered services and self-directed services. The following services are available: Adult Day Health, Assisited Living service, Case Management, Homemaker, Respite, Home Health Aide Services, Nursing Services, Assistive Devices, Chore Services, Consumer Directed Attendant Care, Home and Vehicle Modification, Home-Delivered Meals, Mental Health Outreach, Nutritional Counseling, Personal Emergency Response or Portable Locator System, Senior Companion, and Transportation. Financial Management Services, Independent Support Brokerage Service, Self-Directed Personal Care, Individual Directed Goods and Services, and Self-Directed Community and Employment Supports are available for the individuals who chose to self-direct their services. The level of care determination is made by Medical Services through the Iowa Medicaid Enterprise.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to reduce waitlists and offer a more uniform and equitable system of community support delivery to individuals qualifying for the Elderly Waiver.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

*Note: Item 6-I must be completed.*

A. **Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed

for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Iowa receives public input from various committees and organizations. There is a Senior Living Coordinating Unit, which includes the Departments of Elder Affair, Public Health, and the Department of Inspections and Appeals. This committee meets frequently to discuss elderly issues.

The IME is invited to attend association group meetings where various groups discuss such topics as Assisted Living services, Quality Assurance documentation requirements, case management issues, service planning, cost reporting, etc. Associations include:
* the Iowa Association of Community Providers- monthly meeting,
* Case Management and Mental Health Disability Services (case management) -quarterly meeting,
* Iowa Health Care Association,
*Care Management Alliance of Iowa (case management)- quarterly meeting, and

*Iowa Association of Area Agencies on Aging- quarterly meeting.

The IME has appointed a staff person to attend all Olmstead Taskforce quarterly meetings for input and information.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through public comment hearings, the Legislative Rules Committee, and the Department of Human Services Council. When comments/suggestions are made they are reviewed and taken into consideration for rule changes. IME staff must responds to all written public comments prior to implementation of proposed rules.

The state assures that is has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal. This notification was given to Tribal Governments at least 60 days prior to the submission to CMS. The Medicaid agency has written evidence of this notification.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **Last Name:** | Leann |
| **First Name:** | Howland |
| **Title:** | Policy program manager |
| **Agency:** | Iowa Medicaid Enterprise |
| **Address:** | 100 Army Post Road |
| **Address 2:** | |
| **City:** | Des Moines |
| **State:** | Iowa |
| **Zip:** | 50315 |
| **Phone:** | (515) 256-4642 **Ext:** ☐ **TTY** |
| **Fax:** | (515) 256-1306 |
| **E-mail:** | lhowlan@dhs.state.ia.us |

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **Last Name:** | |

| | |
|---|---|
| **First Name:** | |
| **Title:** | |
| **Agency:** | |
| **Address:** | |
| **Address 2:** | |
| **City:** | |
| **State:** | **Iowa** |
| **Zip:** | |
| **Phone:** | **Ext:** ☐ **TTY** |
| **Fax:** | |
| **E-mail:** | |

## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

| | |
|---|---|
| **Signature:** | |
| | State Medicaid Director or Designee |
| **Submission Date:** | |

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

| | |
|---|---|
| **Last Name:** | Lovelady |
| **First Name:** | Julie |
| **Title:** | Interim Medicaid Director |
| **Agency:** | Iowa Department of Human Services - Iowa Medicaid Enterprise |
| **Address:** | 100 Army Post Rd |
| **Address 2:** | |
| **City:** | Des Moines |
| **State:** | **Iowa** |
| **Zip:** | 50317 |

**Phone:** (515) 256-4621 **Ext:** ☐ **TTY**

**Fax:** (515) 725-1360

**E-mail:** jlovela@dhs.state.ia.us

## Attachments

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

Section I: Assessment Milestones
04/01/2014-04/15/2014 Site of service breakdown: State identifies site of service possibilities for HCBS services not excluded from the settings expectations.
04/15/2014-04/30/2014 Site of service sort: State identifies which general sites of service have qualities of an institution or are HCB.
05/01/2014-05/15/2014 Assessment of site of service viability: State assesses HCBS settings as they conform to HCBS characteristic and ability to adjust in future (Yes, Not Yet, No)
05/01/2014-06/31/2014 Incorporation of Assessment into HCBS Unit, BHO Provider Credentialing, and Iowa Medicaid Provider Pre-Enrollment Screening Reviews: State will meet and operationalize mechanisms to incorporate individual setting assessments, flagged member surveys, and HCB technical assistance into existing processes.
05/01/2014-07/31/2014 Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses on File: State will use GIS to analyze potentially isolating locations of provider sites and congregate member living.
06/01/2014-04/31/2015 Site of service - individual identification (QOI): State identifies providers with sites of service that have qualities of an institution.
06/01/2014-04/31/2015 Site of service - individual identification (HCB): State identifies providers with sites of service that have qualities HCB.
12/01/2014-02/28/2015 Enrolled HCBS providers self-assess: All enrolled HCBS providers will submit additional information on their Provider Self-Assessments to assist in data collection.
06/01/2014-10/31/2014 Other projects collecting HCBS setting data: State consultant will incorporate HCBS setting questions into existing provider surveys. State provider stakeholder association will survey residential providers and provide findings to the state.
04/01/2014-In Perpetuity Iowa Participant Experience Survey (IPES): State will continue to monitor their IPES results to flag member experience that is not consistent with assuring control over choices and community access.
05/01/2015-06/31/2015 Onsite Assessment Results Report: State compiles and analyzes findings of onsite assessments.
07/01/2015-07/31/2015 Onsite Assessment Results Report Presentation: State formally presents findings of onsite assessment to DHS management and stakeholders.

Section II: Remedial Strategies
06/01/2014-07/31/2016 Informational Letters: State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO will provide the same information to provider network.
08/01/2014-07/31/2015 Iowa Administrative Code: State will work to revise programmatic rules to reflect final regulations on HCBS setting requirements. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of member control of their environment and access to community. BHO will develop the same standards for provider network.
08/01/2015-12/31/2015 Provider Manual Revisions: State will work to revise HCBS provider manuals to incorporate regulatory requirements for HCB and qualities of an HCB setting. BHO will incorporate the same information into relevant provider network manuals.
05/01/2014-03/17/2019 (and beyond) Incorporate Education and HCB Compliance Understanding into Provider Enrollment: Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that they can assess HCB settings when appropriate. When agencies enroll to provide HCBS services, they will be provided technical assistance on HCB setting requirements and be required to certify that they have received, and understand, these setting requirements.
07/01/2014-06/30/2016 Provider Assessment Findings: State will present each provider with the assessment of their organizational HCBS settings as determined though state review or provider self-assessment.
08/01/2014-03/17/2019 Provider Individual Remediation: HCBS providers will self-disclose remediation plans or state will preset remediation requirements for each organization's HCB settings. Providers will be required to submit periodic status

updates on remediation progress. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular bases.
04/01/2014-03/17/2019 Data Collection: State and BHO will collect data from reviews, technical assistance, updates, etc. to track status of non-HCB sites and transitions made. Data will be reported on a regular basis or ad hoc to upper management and CMS.
08/01/2014-10/31/2014 Compliance Tool: State will develop tool utilized to capture level of compliance with HCB compliance following remediation.
07/01/2015-03/01/2019 Onsite Compliance Reviews: State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCB settings following completion of their remediation schedule.
08/01/2014-03/17/2019 (and beyond) Provider Sanctions and Disenrollment: State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.
08/01/2014-03/17/2019 (and beyond) Member Transitions to HCB Compliant Settings: If necessary, the state will work with case managers, service workers, and care coordinators to ensure that members are transitioned to providers meeting HCBS Setting Requirements or have fully cooperated in the transition process. Members will be given timely notice and a choice of alternative providers through a person centered process. Transition of members will be comprehensively tracked to successful placement and continuity of service.

Section III: Public Comment
05/01/2014-05/31/2014 PSA - Assessment Plan and Public Input: State shares method of assessment with public stakeholders, asks for input, and designates LTC point of contact.
05/01/2014-05/31/2014 Public Comment Period and Meetings - Proposed Transition Plan: State commences stakeholder forums, shares proposed transition plan with public, collects comments, develops summary of comments for CMS, summary of state response to public comments, and incorporate appropriate suggestions into transition plan,. The state will document all iterations of the transition plan.
05/01/2014-03/17/2019 Public Comment Retention: State will safely store public comments and state responses for CMS and public consumption. State will publically post FAQs on an ongoing basis.
05/01/2014-03/17/2019 Posting of Transition Plan Iterations: State will post all iterations of the transition plan and rationale with narrative rationale for changes made.
07/01/2015-07/31/2015 PSA - Assessment Findings Report: State shares the findings of the onsite assessment

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Currently, the state is in the process of assessing the HCBS settings. The transition plan for the Elderly waiver was posted to the IME website for public comment from November 1, 2014, through November 30, 2014. Currently, the state has not completed any milestones within the transition plan but shall begin to do so within the month.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):