Essential Elements of Managed Long-Term Services and Support (LTSS) Programs

Presenters:
Gayla Harken
Brita Nelson
Lisa Schwanke

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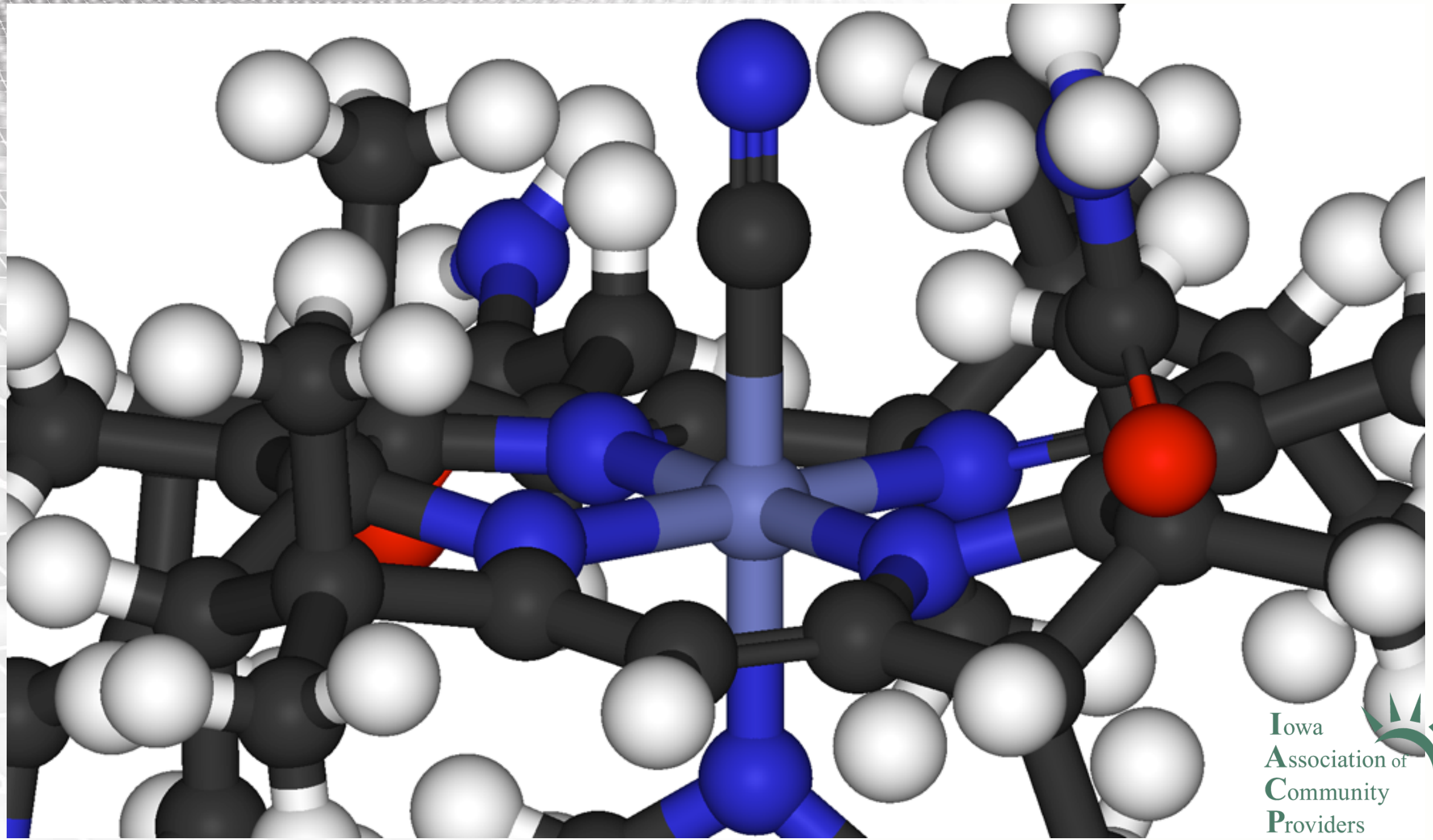

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Element 1: Adequate Planning

Provides adequate time to engage in:

- Thoughtful planning and design
- Incorporate stakeholder input
- Implement safeguards to ensure a smooth transition and effective on-going implementation

States must maintain oversight before, during, and after the transition from fee-for-service (FFS).

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Element 2: Stakeholder Engagement

Regular engagement of stakeholders, including cross-disability representation of participants, community, providers and advocates. Must have a formal process for ongoing education of stakeholders prior, during, and after implementation. States must require contractors to have such formal processes and education as well.

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Element 3: Enhanced Provision of HCBS

- States must require MCOs to offer services in the most integrated setting possible.
- MLTSS must provide the Greatest Opportunities for Active Community and Workforce Participation.

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HCBS Setting Requirements

MCO - Scope of work Section 4.4.4

Provider Manuals:

- Amerigroup - page 63
- AmeriHealth Caritas - page 163
- UHC - page 31

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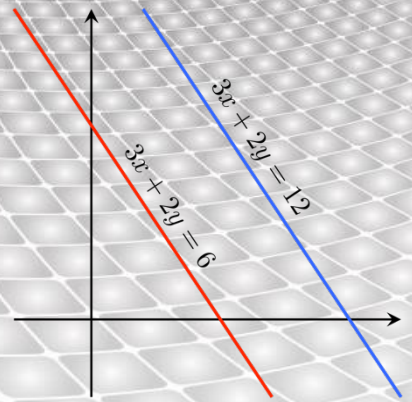
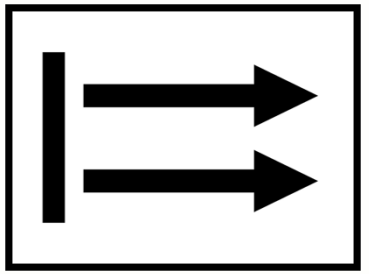


Element 4: Alignment of Payment Structures and Goals



Payment structures must be designed to support the goals of the MLTSS program and essential elements of MLTSS. Providers should be held accountable through performance-based incentives and/or penalties. States must evaluate payment structures and make changes necessary to support the goals of their programs.

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Element 4: Alignment of Payment Structures and Goals (con't)

Payment structures must encourage the delivery of community-based care.

States must employ financial incentives that achieve desired outcomes and/or impose penalties for non-compliance or poor performance.

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Element 4: Alignment of Payment Structures and Goals (con't)

These goals may reward MCOs for activities such as providing supports to aid participants in achieving competitive employment, the provision of services in the most integrated setting, and consumer satisfaction. Penalties should discourage operations and outcomes that are contrary to state goals and may include, for example, financial penalties for not meeting contractual deadlines or return of a payment if an MCO does not achieve required outcomes for the provision of services in the most integrated setting.

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Element 5: Support for Beneficiaries

Participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, and consumer friendly.

FYI: States must permit participants to disenroll and switch to another MCO when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment.

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Element 5: Support for Beneficiaries (con't)

- Counseling can be provided in any number of ways; but to ensure independence, counseling must be provided by an entity that is not:
  - a health plan
  - a service provider
  - an entity making eligibility determinations.

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Element 5: Support for Beneficiaries (con't)

- States must ensure an ombudsman program is available to assist participants:
  - in navigating the MLTSS landscape
  - understanding their rights, responsibility, choices, and opportunities
  - helping to resolve any problems that arise between the participant and their MCO.

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Element 6: Person-Centered Processes

- Must require and monitor the implementation and use of person-centered:
  - needs assessments
  - service planning/coordination

- MLTSS programs should encourage participant self-direction and provide opportunities for self-direction of services.

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Element 7: Comprehensive Integrated Service Package

Must provide and/or coordinate the provision of all physical and behavioral health services and LTSS (including institutional and non-institutional) and ensure participants receive those services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and services planning process.

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Element 8: Qualified Providers

Must ensure MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract. For state transition from FFS to MLTSS, states should encourage/require incorporation of existing LTSS providers as MCO network providers to the extent possible. States must provide or require MCOs to provide support to traditional LTSS providers, which may include areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.

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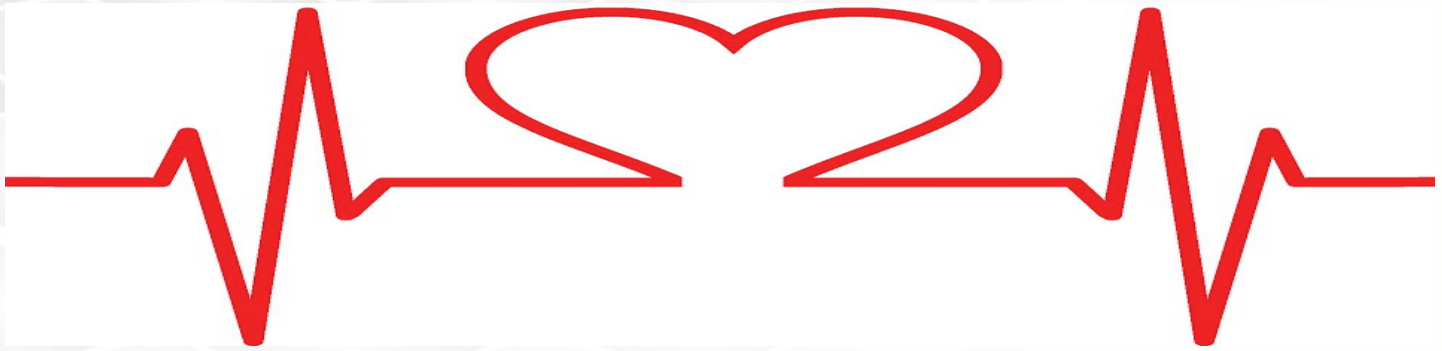
Element 9: Participant Protections

Must establish safeguards to ensure participants' health and welfare is assured within the MLTSS program, including a statement of participant rights and responsibilities; a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and fair hearing protections, including the continuation of services during an appeal.



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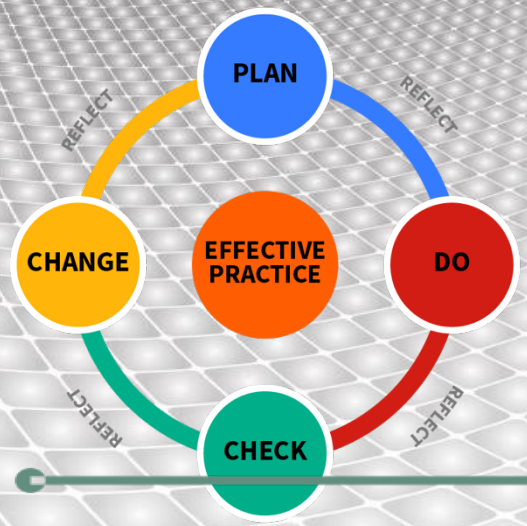

Element 10: Quality

Expected to maintain the highest level of quality in all MLTSS operations and series through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies.

The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population.

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External Quality Reviews

The Balanced Budget Act of 1997 requires state Medicaid agencies that contract with MCOs to develop a state quality assessment and improvement strategy consistent with Department of Health and Human Services (HHS) standards.

Link to Federal code:
https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.364

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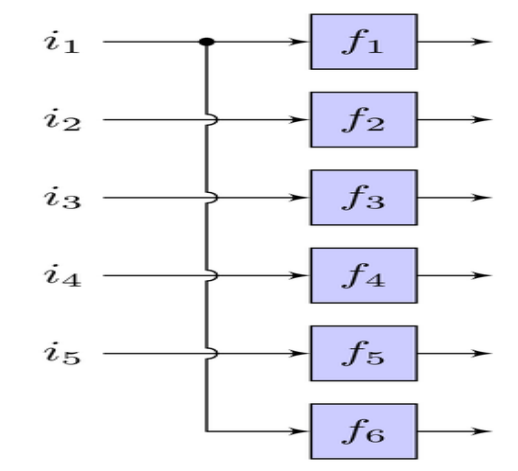
Eight Protocols

There are eight protocols that provide detailed instructions to states and EQROs to guide their performance of EQR.

- Three are mandatory.
- Five are voluntary.
- A fourth mandatory protocol was added May 6, 2016: Validation of network adequacy (new).



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Protocol 1: Assessment of Compliance (Mandatory)

This includes:

- Accessibility
  - including physical accessibility of service sites, accessibility of information (...literacy levels of written materials, alternate formats), and other accommodations to ensure the individual is fully participating and understands the information

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Protocol 1: Assessment of Compliance (Mandatory)

- Availability and use of HCBS as alternatives to institutional care, such that individuals can receive the services they need in the most integrated setting appropriate.

- Credentialing or other selection processes for LTSS providers
  - such as verification of completion of criminal background checks.

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Protocol 1: Assessment of Compliance (Mandatory)

- Person-centered:
  - assessment
  - person-centered care planning, service planning, and authorization
  - service coordination and care management for LTSS
  - This includes:
    - Authorization/utilization management
    - Beneficiary rights or protections related to care planning and service

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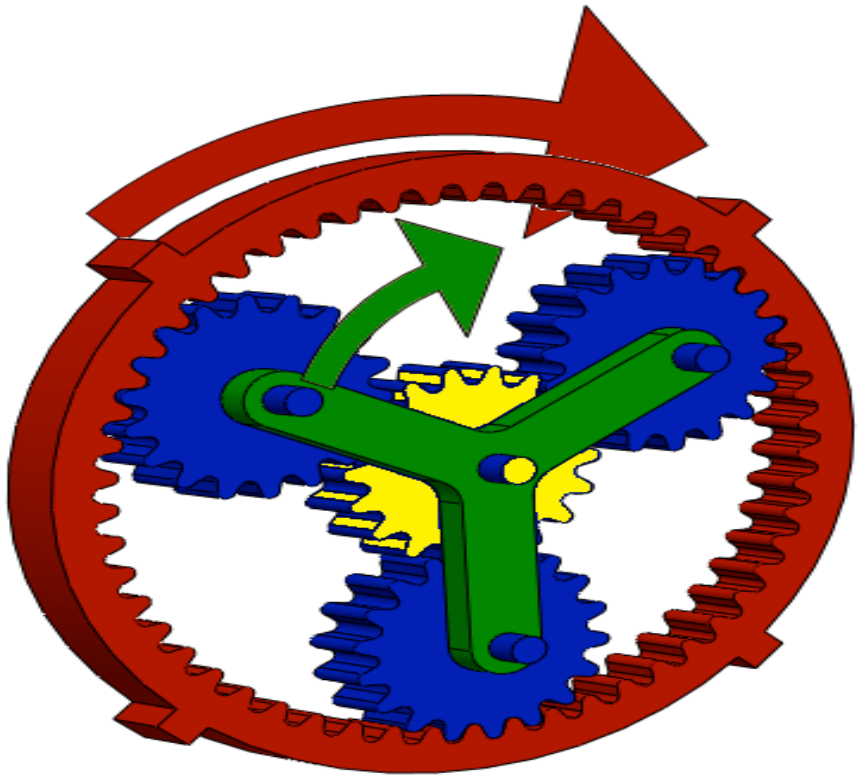
Protocol 1: Assessment of Compliance (Mandatory)

Integration of managed medical, behavioral, and LTSS



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Protocol 2: Validation of Performance Measures Reported by the MCO (Mandatory EQR Activity)

"Assess the Integrity of the MCO's Information System"

- States should consider LTSS, including, as applicable, specific subsets of LTSS such as
  - personal care services
  - equipment and supplies
  - transportation
  - home modifications
  - supported employment
  - and other waiver services

  when evaluating the accuracy and completeness of data used to measure each service.

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Protocol 2: Validation of Performance Measures Reported by the MCO (Mandatory EQR Activity)

"Review Information Systems Underlying Performance Measurement"

- States should include LTSS claims and encounters, case management systems, and any other data systems that capture information from beneficiary care plans or service plans as additional primary data sources.

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Protocol 3: Validating Performance Improvement Projects (PIP)
(Mandatory EQR Activity)

- The purpose of the protocol is to guide the EQRO in assessing the validity and reliability of a PIP. It includes three activities:
  (1) assessing the study methodology
  (2) verifying the study findings
  (3) evaluating the overall validity and reliability of the study results.
- States should consider requiring PIPs or PIP topics that are uniquely relevant to managed LTSS.

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Protocol 3: (1) Assessing the Study Methodology

The protocol states that the PIP, over time, should address a broad spectrum of enrollee care and service. It lists 8 examples of sub-populations and dimensions of care and services. Although these are just examples, states should also include, where applicable, adults with physical disabilities, people with intellectual and developmental disabilities, and people with dual eligibility who use LTSS as additional enrollees whose care and services should be addressed by the PIP.

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Protocol 3: (2) Verifying the Study Findings

In "Notes to Reviewers," the protocol defines outcomes as "changes in patient health, functional status, or satisfaction resulting from the PIP." States should additionally consider avoidable hospitalizations or Emergency Department visits, which can serve as indicators of care coordination, reductions in institutional placement or length of stay, individual choice and control, and individual goal achievement (for example, employment or participation in the community) as important outcomes.

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Protocol 3: (3) "Review the Data Collection Procedures"

Data sources listed are:

(1) Beneficiary medical records

(2) Tracking logs

Beneficiary interviews

(3) Encounter and claims systems

(4) Provider interviews

(5)

(6) Surveys

States should also consider sources of information about LTSS, such as EVV, case management systems, individual assessments, and care and/or service plans.

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Protocol 4: Validation of Encounter Data (Voluntary)

Much of this protocol parallels the process outlined in Protocol 2 for the validation of performance measures reported by the MCO. Encounter reporting for home- and community-based LTSS is more incomplete and less standardized relative to medical care encounters. States should establish standards for encounter reporting in their contracts, including defining what constitutes a reportable encounter. In doing so, states should consider the various types of LTSS, the relevant service units, and how they might be reflected as encounters.

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Protocol 5: Validation and Implementation of Surveys (Voluntary)

The protocol includes 8 activities related to survey implementation:

1. Identify survey purpose(s), objective(s), and intended use
2. Select the survey instrument
3. Develop the sampling plan
4. Develop a strategy to maximize the response rate
5. Develop quality assurance plan
6. Implement the survey
7. Prepare and analyze data obtained from the survey
8. Document the survey process and results.

The protocol presents a parallel set of steps for validating previously conducted surveys. Like Protocol 2 for the validation of performance measures, Protocol 5 does not require specific survey instruments, topics, or targets.

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Protocol 6: Calculation of Performance Measures (Voluntary)

The protocol states that the EQRO may need to conduct medical record review to obtain necessary data. Because LTSS encounters will likely not be reflected in the primary care medical record, states should consider the broader definition of medical record as inclusive of all individual health, behavioral, or other long-term services and supports documentation such as might be found in case management systems, assessments, and care and/or service plans and care notes.

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Protocol 7: Implementation of Performance Improvement Projects (Voluntary)

The protocol lists a number of potential data sources. States should consider adding case management systems, EVV systems, and other data sources that provide information about LTSS.

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Protocol 8: Conducting Focused Studies of Healthcare Quality
(Voluntary)

The process of conducting focused studies mirrors most of the activities of Protocol 3 for validating PIPs and Protocol 7 for implementing PIPs. Most of the details of the activities are incorporated from Protocol 3 by reference. This protocol may be particularly useful to states that wish to conduct special studies focusing on LTSS.

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New Addition: 4th Mandatory Protocol: Validation of Network Adequacy

See Scope of Work Document - Exhibit B

Example: HCBS Providers: All certified, accredited, or approved HCBS providers shall be offered inclusion in the Contractor's provider network for two (2) years in accordance with Section 6.2.2.6. The Contractor shall contract with at least two (2) providers per county for each covered HCBS in the benefit package for each 1915(c) HCBS waiver. In the event a county has an insufficient number of providers licensed, certified, or available, the access standard shall be based on the community standard and shall be justified and documented to the State.

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements

14.5.5.1 Behavioral Health

(i) follow-up after inpatient hospitalization for mental illness;

(ii) readmission rates for psychiatric hospitalizations;

(iii) anti-depression medication management; . . .

(v) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; . . . . .

(x) a report that identifies foster children by a common identifier who are on two (2) or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern.

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements (con't)

14.6.4 ICF/ID and PMIC Report: The ICF/ID and PMIC report shall document measures for ICF/ID and PMIC services to be determined by the Agency.

14.6.7 Self-Direction: The Self-Direction report shall document the number of members who are self-directing eligible HCBS as described in Section 4.4.8. The Agency will establish a baseline rate and the Contractor shall demonstrate an increase in self-directed services.

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements (con't)

14.6.10 Care Plan and Case Notes Audit the Agency: reserves the right to conduct an audit, or to utilize a subcontractor to conduct an audit, of 1915(c) HCBS waiver care plans and case notes to determine Contractor compliance with:

(i) timely completion; . . . .

(iii) member signature on the care plan;

(vi) plan for supports available to the member in the event of an emergency are documented;

(vii)provision of services as delineated in the care plan;. . .

(x) member and/or guardian participation in care plan development. . .

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements (con't)

14.6.11 Critical Incident Reporting

This report shall document, at minimum, the number, percent, and frequency of critical incidents and the number and percent reported within the required timeframes. The Agency will monitor critical incident reports submitted by the Contractor to identify potential performance improvement activities.

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements (con't)

14.7 Quality of Life Reports and Performance Targets

The Agency intends to develop reports, baseline data, and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to:

(i) increased life expectancy;

(ii) number and percentage of members who gain and maintain competitive employment;

(iii) number and percentage of members engaged in volunteer work.

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SOW Requirements - Section 14 Performance Targets and Reporting Requirements (con't)

(iv)satisfaction;
(v) reduction in homelessness.
The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders, and shall have the EQRO validate the findings.

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Questions

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References

Medicaid.gov - Managed LTSS
https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

For current information on 8 protocols:
https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

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References

To find Scope of Work - the bidders library page on DHS's website (link below). Click on any of the MCO contracts - the scope of work is attached to each contract.

https://dhs.iowa.gov/MED-16-009_Bidders-Library

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Acronyms

MLTSS - Managed Long Term Services and Supports
FFS - Fee for Service
EQRO - External Quality Review Organizations
BBA - Balanced Budget Act
PIP - Performance Improvement Project
EVV - Electronic Visit Verification
SMA - State Medicaid Agency

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Q&A: You ask, We Answer

November 2016

Presenter: Brita Nelson

Gayla Harken

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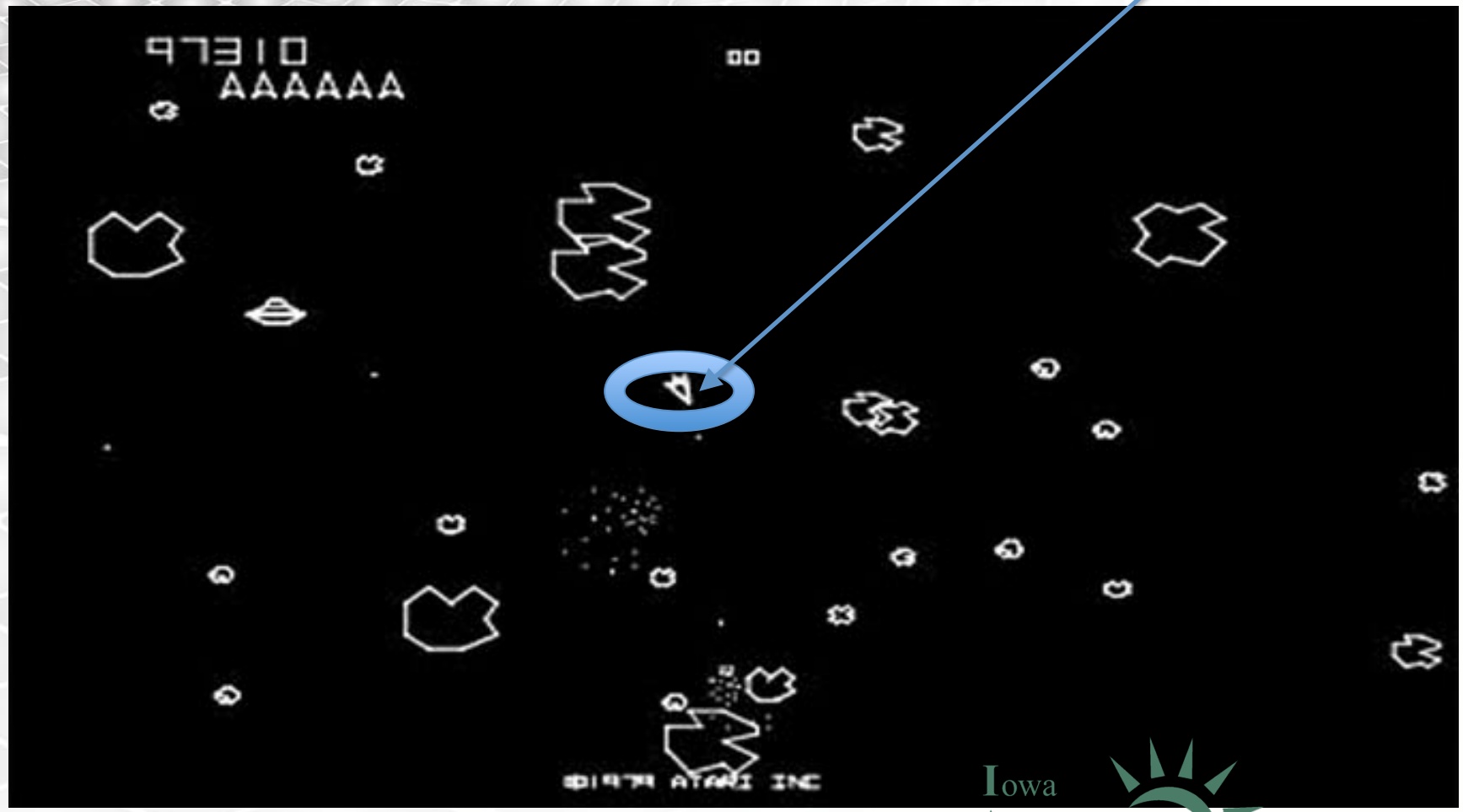
Ever Feel Like This?



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Change is everywhere

- Managed Care
- OSHA
- HCBS Settings Rules
- HIPAA
- Overtime Rules
- Home-Care Rule

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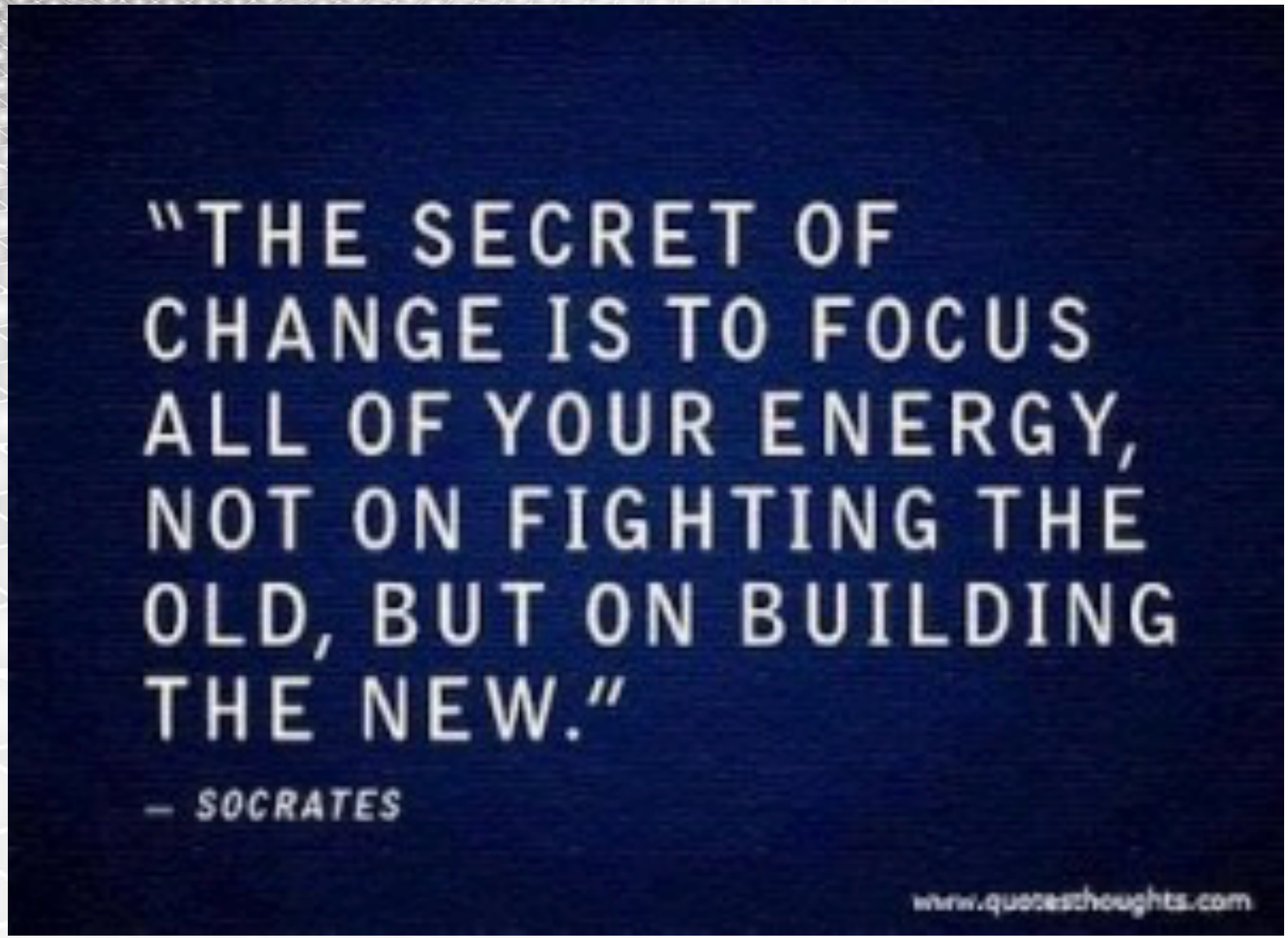

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Q: Do all providers need to re-enroll in Medicaid? Why is this being done? It seems like unnecessary extra work.

A: Yes. Medicaid provider must re-enroll. The deadline depends on whether you are a high risk or moderate/limited risk provider. If you are limited risk, your deadline is December 31, 2016. Several ILs explain the process: https://secureapp.dhs.state.ia.us/IMPA/Information/ViewDocument.aspx?viewdocument=c994f87d-a55c-4975-8b5a-232fc0197ee5

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Q: I heard that the DOL Overtime Rules have been delayed. Is this true?

A: No. This update to the DOL Fair Labor Standards Act still stands. There are a few proposed pieces of legislation, though nothing has passed at this point.
They are still moving forward with December 1, 2016

(We are not lawyers, so please consult your legal counsel as you consider implementation options. What we know follows.)

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…DOL Overtime Date…

- If exempt staff do not make at least $47,476 annually, they are eligible for overtime for any hours over 40 worked during the pay week.
- Staff can still be salaried if they work less than that, however, will still be eligible for overtime for hours over 40.
- Recommend having your exempt staff start tracking their hours now (if you haven't started already) to get idea of impact.
- National Council did a detailed webinar and it can be viewed here: http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/?pageno=2&sortby=Most+Recent#foobox-1/0/Ly2d1nrM69s

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Q: I heard the DOL Overtime rules don't apply to residential providers. Is that true?

A: In short, no. The limited enforcement policy is far more limited than residential providers.

- The rules still apply. However, for certain types of providers, there was a **policy decision** for DOL to have a period of non-enforcement. (Policy decision does NOT = rule change.)
- This means that DOL will not fine these providers for lack of compliance until March 2019.
- HOWEVER, employees can still sue you to comply as the rule still stands.
- DOL Fact Sheets on this can be found here: https://www.dol.gov/whd/overtime/final2016/nonenforcement-faq.htm

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…DOL Overtime Limited Enforcement Policy…

From DOL Website:

The effective date for the Overtime Final Rule is December 1, 2016. The Department of Labor (the Department) is, however, implementing a limited non-enforcement policy for providers of **Medicaid-funded** services for **individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds.** This non-enforcement period will last from December 1, 2016, to March 17, 2019.

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Q: Any good resources on WIOA?

A: Glad you asked:

Limitations on the Use of Subminimum Wage

WIA is Now WIOA: What the New Bill Means For People with Disabilities

The Workforce Innovation and Opportunity Act

Webinar: WIOA - What's that Got To Do With Us?

Recording and PPT Link can be found here:

http://www.iowaproviders.org/trainings/technical_assistance.html

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Q: What is the status on pre-vocational training? We have closed our workshop, but have a number Case Managers asking why. Did we jump the gun in shutting down the shop?

A: This may make it easier for you to comply with the HCBS settings standards. No services were “outlawed” though the setting rules, however, it does add significant looks at facility-based services.

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Q: I have been told that we can not have our administrative offices in the same building that we provide any services. I can not find this ruling anywhere in the administrative rules. Could you please clarify this for me?

A: Staff offices in a building where you provide services increases the potential scrutiny that may be placed on that specific location. This practice is not against any specified rule.

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Q: I have a concern about the EVV system all providers will need to implement in Jan 2017. Not all clients have phones, let alone landline phones. And, we shouldn't be forcing clients to let staff use their phones and/or have a phone they may not be able to afford. Also, what's the cost to the providers for the EVV system to be used?

(See next slides.)

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…EVV…

A: We hear you. This will be a major transition for many providers.

EVV = Electronic Visit Verification

It is one of the ways the MCOs have chosen to implement fraud, waste and abuse protections under the managed care contract.

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…EVV…

What we know right now:

- There is a workgroup of staff from MCOs and IME looking at EVV, the chosen vendors and process for implementation.
- EVV has already been utilized in Iowa for home health providers.
- Implementation is NOT January 2017, rather calendar year 2017. IL1718-MC states: “All MCOs will implement EVV in calendar year 2017”
- https://dhs.iowa.gov/sites/default/files/1718-MC_ElectronicVisitVerification.pdf

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Q: Regarding EVV, do we know what vendors have been chosen?

A: Not officially, as nothing is final. We do know the companies they planned to use before the implementation date was pushed.

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Q: Why must we continue to complete Cost Reports for IME when the MCOs are setting the rates now?

A: DHS has said they are using them for informational purposes only, and that if we don't complete them, we'll have nothing to show what our real costs are.

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Q: HOW WILL COST REPORTING IMPACT RATES?

A: There is no impact. DHS has said that the rates you get back will be a tool to utilized to negotiate with the MCOs.

We understand the MCOs have said that rates are based on historical usage amounts from DHS and that contracted rates will remain.

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Q: For new employment rules, can part of the service be given in a non-integrated setting, e.g. training on how to put together a resume or how to search for jobs on the internet?

A: Yes, though this depends on the service.

The settings rules will not limit any particular setting, but you need to look at the person centered plan, the experience of the person, and how this is applied.

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Q: What are the State reporting requirements for the IHHs going forward?

A: We don't know. It is in discussion.
All measures and requirements are currently being defined.

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Q: We are experiencing many changes around home based habilitation--changes in tiers, the use of CSS, etc. What do you know about that?

December 6, at the FFA builiding (DMACC campus) from 10 to 3:30 there will be a meeting to discuss the use of Hab services. MCOs, IME, IHH's, and Providers are invited.

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Q: Outcomes - could always use more training on what outcome structures are potentially going to be in place for the managed care environment. Thanks!

Answer:

A. QSDA

B. MCO reports--Quality of Life Measures and HEDIS

Some things are required now and are known, but there is much discussion still going on

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...Outcomes...

As you prepare your organization to report on outcomes, start with education on what ***outcomes*** are vs ***outputs.***

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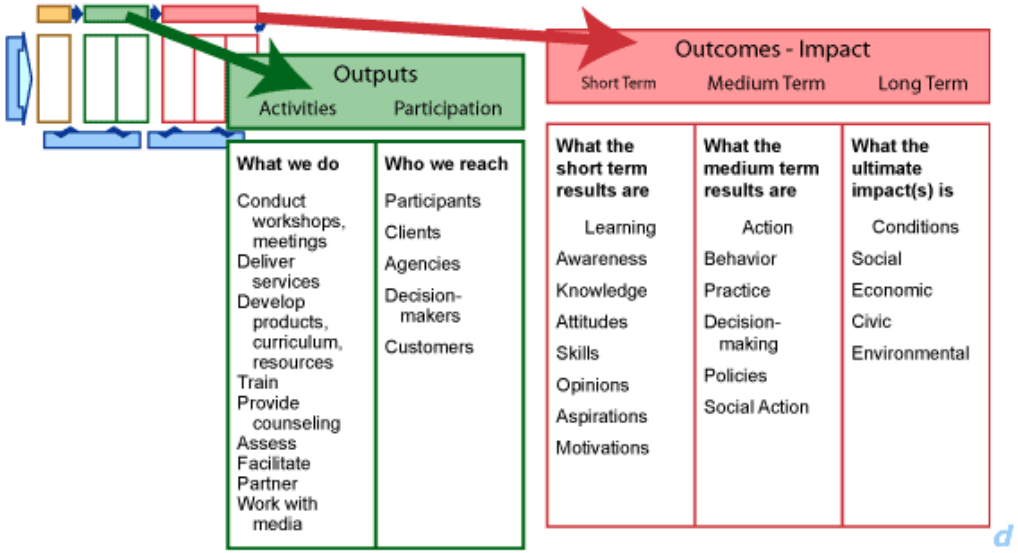
...Outcomes...

Outputs vs. Outcomes

Understanding the difference between outputs and outcomes is important.
Outputs relate to "what we do." **Outcomes** refer to "what difference is there."



In the past, we've tended to focus on what is included in the outputs column - the "what we do and who we reach." We are anxious to tell our clients, funders and community partners what it is that we do, the services we provide, how we are unique, who we serve... We've done a good job of **describing** and **counting** our activities and the number of people who come. Now, however, we are being asked: "What **difference** does it make?" This is a question about OUTCOMES.

In some logic models you will see activities separated from outputs; activities may be displayed before outputs. In those models, outputs are typically designated as the **accomplishment** or **product** of the activity... for example, number of workshops actually delivered, number of individuals who heard the media message. The assumption is that the activity needs to be delivered as intended before the expected outcomes can occur. We see this as part of measurement (quantity and quality of implementation) and as such is covered in Section 7.

Q: Any updates on the status of the CSN Portal?

A: We have asked for providers to have additional access to the portal to allow them to make changes to things like member address (currently you have to go through region to do this).

We know this is being looked at along with the regions, though it is still in discussion.

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Q: Are the case managers for MCO's required to do social histories on individuals? If so, how do we get them from them?

A: We believe this continues to be required. IME has said that nothing has changed or been suspended/repealed when related to case management.

As far as getting the info from case managers… you need to communicate your needs, and ask for assistance if you are not getting what regs require

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Q: What requirements are the MCO's wanting different with documentation on individuals?

A: The rules for regular service documentation have not changed. There is a focus on documenting that services are participant-driven and wishes of the member are followed.

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Q: WHEN WILL THE JULY 1ST 1% RATE INCREASE BE IMPLEMENTED BY IME AND MCOS?

A: We have been told the MCOs are in the process of reprocessing claims back to July 1 to pay providers the 1%. What is your experience?

IME has published emergency rules that are set to take effect November 9.

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Q: Whose responsibility is it to address provider shortages in work services and Children's Mental Health Waiver?

A: Provider adequacy is up to each MCO.

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Q: Will we be required to do a cost report for the 2016/2017 year?

A: As far as we know, yes. The schedule will be the same.

Iowa Association of Community Providers

Q: Is something still in the works for moving other services to tiered structure?

A: Yes. DHS is currently meeting with a consultant to develop payment methodology based on costs.

Will meet with MCOs and provider group in the next month.

What services are being included in this? ***ID Waiver*** cost reported services initially (SCL & DayHab).

- The current model is based on the SIS score.
- Historical cost information based on prior utilization

Iowa Association of Community Providers

More on HCBS Employment Training Requirements

- November 4 (yea, this week) is the training deadline for the 9.5 hours of training required for staff to bill services.

- If you don't have this handled, talk to Brita about DirectCourse's College of Employment Services.

DHS FAQ Regarding this Rule:
https://dhs.iowa.gov/sites/default/files/FAQ_HCBS_Prevocational_and_Supported_Employment_Services_0.pdf

Iowa Association of Community Providers

Q: We have heard that OSHA is taking a serious look at incidents that have taken place in HCBS settings. Is this true?

A: Yes, we are aware that OSHA has been to investigate a few situation in Iowa's HCBS settings. Providers will need to document how they are addressing dangerous situations and what policies and trainings they have to prove this.

- Who has had them come in the last year?

Iowa Association of Community Providers

Definition of Workplace Violence - OSHA

- Workplace violence is any act or threat of physical violence, harassment, intimidation or other threatening and disruptive behavior that occurs at a work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors.

- OSHA exists to protect employees.

- **Information on OSHA comes from Dr. Jackie Moore**

Iowa Association of Community Providers

Q: The 180 days billing deadline, how does this work?

Your claims for services have to be to the MCO (through the clearing house) within 180 day of the service being rendered. This is different than the state's requirement of 365 days.

If you do not submit payment within this timeframe to the MCO, expect to NOT be paid.

Iowa Association of Community Providers

Q: Are there any updates on the court order requirement for a move to a more restrictive setting?

A: No changes here. If a person with a guardian is moving to a more restrictive setting, Iowa law still mandates that this move be approved by a judge.

For more information on substitute decision making, check out the series of webinars by Iowa's Office of Substitute Decision Maker on the TA pages of www.iowaproviders.org.

Q: When does Iowa DHS anticipate revising the IAC to align with the CMS Integrated Settings?

This will align with the CMS standards and be worked on soon. There will be specific language added to rule that will address some of the settings requirements.

(September/October 2017)

Iowa Association of Community Providers

….IAC Changes….

- Chapter 75 addresses MCOs and some managed care changes.
- IME is in beginning stages of rule revision.
- We would expect provider manuals would be updated after rules are done.
- To an extent, the transition plan addresses the issue of landlord/tenant relationship.

Iowa Association of Community Providers

Q: Where can we locate the Federal rules?

A: CMS has a number of resources on HCBS regulation. Keep in mind states have the ability to be more restrictive than federal rule.

https://www.medicaid.gov/medicaid/hcbs/index.html

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/hcbs-tk1-gen-overview-factsheet.pdf

Iowa Association of Community Providers

Q: Are there any instances where work transportation can be provided and documented by the provider for individuals receiving Habilitation funding?

A: This depends on the Habilitation service. For example, under supported employment, the provider manual says:

Transportation between the member's place of residence and the employment site is a component part of SEIE support services and the cost of this transportation is included in the rate paid to providers of SEIE support services.

Iowa Association of Community Providers

Q:Does the list of rights for individuals need to match the 20 outcomes as listed in the April TA training handout?

A: No, it does not need to match exactly. The 20 Outcomes are the intended result of service delivery; rights are principles that guide services.

Iowa Association of Community Providers

Q: Documentation is one of the harder aspects of the job for Direct Support workers. Can IACP develop a library of examples of goals and the daily documentation for supervisors to show them?

A: Examples are tough as it totally depends on the person's service plan. One key piece is not to have documentation be merely an accounting of the person's time with staff. How did staff intervene (why are they getting paid to be there) and what was the person's response to that intervention.

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…documentation….

- IACP has several archived documentation webinars on the public part of our website as well as on the DirectCourse LMS.
- http://www.iowaproviders.org/trainings/technical_assistance.html
- These recorded webinars are also global modules on the DirectCourse system for any of you who use that system.

Iowa Association of Community Providers

Q: Transportation for CDAC Providers: For both medical and non medical in town transportation (to doctor, Wal Mart, grocery store, etc…) is the CDAC Provider still able to transport Members to shopping and medical appointments and get reimbursed for their service time or are ALL transportation needs to be done through the MCO Transportation Services?

Q: You can provide transportation but don't get reimbursed for cost of transportation. Medical appointments are through NEMT. Other needs covered in the plan can still be provided.

Member can also pay for cost of transportation.

Iowa Association of Community Providers

Q: Medicaid eligibility can be viewed in ELVS and MCO Web Portals. Authorizations can be found in MCOs' Web Portals. However, Medicaid Waiver eligibility cannot be viewed in most MCOs Web Portals. How do providers confirm Level of Care Waiver eligibility, and where to look for this information, with each of the MCOs or IME?

IME is aware that status is not available in ISIS once an MCO is assigned. There are solutions being worked on to address this drop off in eligibility

Iowa Association of Community Providers

Q: How often and when is the LOC information loaded into MCOs' web portals? If we view the web portal on the 2nd of the month, will the information be accurate for that month? Thank you :)

A: DHS has said that this information is sent to MCOs daily.

Each MCO has a different process for loading the information into forward-facing databases/portals.

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Q: Where are services headed under MCO funding and oversight?

A: HUGE question!

We know in other states, it takes between 12-24 months for things to ‘settle’. Plan for upcoming increase in MCO quality assurance and discussion on outcomes.

Iowa Association of Community Providers

Q: I would like to learn more about the billing reconsideration for each MCO. Meaning 1) how to get claims adjusted if there was an unit error in the original submission, 2) how to have a claim reconsidered if rejected or denied (without having to contact our provider liaison each time), and 3) access to forms and procedure printouts each one has to complete this process.

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...billing reconsideration...

A: The answer depends on many variables.

Did you bill correctly?
What is your contracted rate?
Are you contracted correctly for that service?
Have you contacted your provider liaison?
Appeal process

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...billing reconsideration...

From IME Newsletter:
http://myemail.constantcontact.com/Medicaid-e-News--Important-Updates-and-Reminders.html?soid=1123163422953&aid=Jrdv4fthDOc

Learn More About Your Rejected and Denied Claims:
When a claim is rejected, reports explaining the reason for rejection are available to providers through their electronic clearinghouse.

When a claim is denied, reports explaining the reason for denial are provided by the Managed Care Organization (MCO).

Both of these reports include the denial/rejection code and a corresponding explanation. For more information on locating or accessing these reports contact your clearinghouse and/or MCO.

Clean Claims: All information required for processing is present.

Denied: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

Suspended: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

Rejected: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

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Q: I heard people are getting HIPAA reviews . Is this real?

A: Yep. It sure is.
Have you done a risk assessment? If not, DO IT NOW.

http://www.hhs.gov/about/news/2014/03/28/hhs-releases-security-risk-assessment-tool-to-help-providers-with-hipaa-compliance.html

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…HIPAA…

- There are hundreds of HIPAA reviewers going around the country to gauge compliance with HIPAA and HITEC. These reviewers may have a specific focus upon entry into an agency, though, once there, have the ability to change focus based on findings.

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Q: Anything new on the ABLE Act?

A: There are currently three versions of updates to the ABLE act in various bills in congress, though there are no changes yet. Federal rules are still being promulgated.

ABLE National Resource Center has lots of great state-by-state information. http://www.ablenrc.org

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Q: Are there changes upcoming federally we need to know about?

- The Proposed Disability Community Act
- ANCOR's SOS Campaign: http://amplifier.ancor.org/saveourservices

- ANCOR is working diligently to get federal legislators to approve funding necessary for disability service providers to survive and thrive in the future.

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Useful Past Training Links

Past TA trainings, webinar recordings and resource links can be found on the Technical Assistance pages of the IACP website.

http://www.iowaproviders.org/trainings/technical_assistance2.html

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Upcoming Trainings

- November 15, 2016 @ 10:30AM - WEBINAR - Employment Services Series: Session 2
  https://global.gotowebinar.com/pjoin/4868105702117348354/7848351760413496322
- November 21, 2016 @ 10:30AM - WEBINAR - WIOA: The Iowa Details
  https://attendee.gotowebinar.com/register/4868105702117348354

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Upcoming Trainings

- December 6 - IHH & Habilitation Meeting with MCOs @ Ankeny FFA Building

- December 19, 2016 @ 2PM - WEBINAR - Iowa's Long Term Care Ombudsman Office https://attendee.gotowebinar.com/register/3329906527044579074

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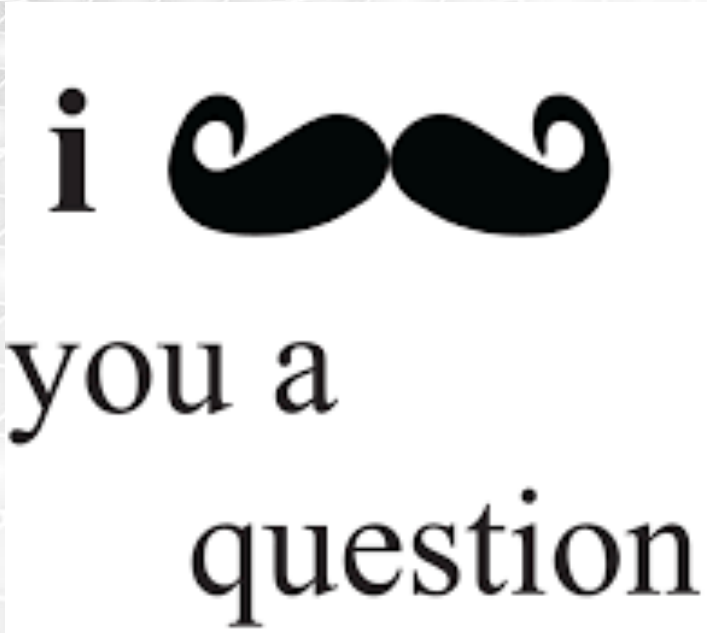
Questions?



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IOWA'S HCBS SETTINGS TRANSITION PLAN: WHAT PROVIDERS NEED TO KNOW

November 2016

Presented by: Gayla Harken
Brita Nelson

Iowa Association of Community Providers

Relentlessly advocating for Iowa providers to build healthy communities.

Settings Rule Overview

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The Final Rule

Addresses both HCBS settings as well as person-centered planning

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Person-Centered Planning

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

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Overarching Settings Theme as Stated in Rule

- *"The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."*

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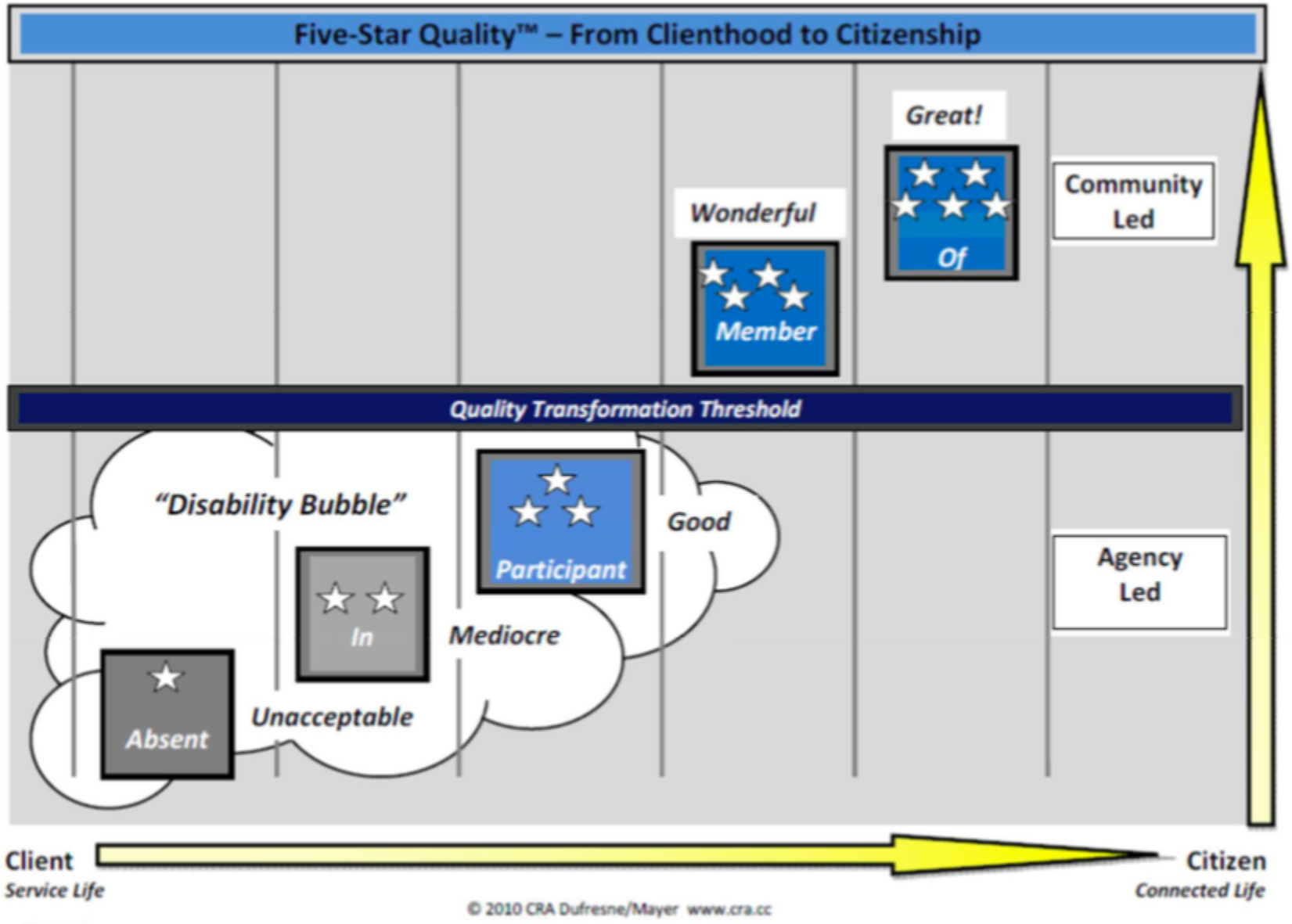

Figure 1

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HCBS Setting Requirements

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting
- Ensures an individual's rights of privacy, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports and who provides them

Additional Requirements for Provider-Controlled or Controlled Residential Settings

Distinguishing between Settings under the HCBS Rule

Settings that are not HCB

- Nursing Facilities
- Institution for Mental Diseases (IMD)
- Intermediate care facility for individuals with I/DD (ICF/IID)
- Hospitals

Settings presumed not to be HCB

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals not receiving Medicaid HCBS.

Settings that could meet the HCB rule with modifications

- Settings that are HCB but do not comport with one or more of the specific requirements outlined in the final rule.
- May require modifications at an organizational level, and/or modifications to the PCP of specific individuals receiving services within the setting.
- Must engage in remediation plan with the state, and complete all necessary actions no later than March 2019.

Settings presumed to be HCB and meet the rule without any changes required

- Individually-owned homes**
- Individualized supported employment
- Individualized community day activities

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Where HCBS Cannot Be Provided

This includes settings that have **always** been statutorily excluded such as hospitals, nursing facilities, ICF/IDs, or institutions for mental disease (IMDs). However, the rule also goes a step further and describes settings that are presumed to have the qualities of an institution

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Setting Presumed Not to Be HCBS

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

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CMS: Settings with the Effect of Isolating Individuals

CMS' *Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community* states that the following two characteristics alone might, but will not necessarily, have the effect of isolating individuals:

- The setting is designed specifically for people with disabilities, or for people with a certain type of disability

- Individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provides services to them.

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CMS: Settings with the Effect of Isolating Individuals: EXAMPLES

Farmstead of disability-specific farming community

Gated/Secured "community" (intention communities)

Residential Schools

Multiple settings co-located and operationally related

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Settings with the Effect of Isolating Individuals: Farmsteads or Disability Specific Farming Community

A farmstead or disability-specific farm community that has the following characteristics:

- Individuals who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals.

- Daily activities and non-home and community-based services, such as religious services, take place on-site so that an individual generally does not leave the farm

- People from the broader community may sometimes come on site, but people from the farm seldom go out into the community as part of daily life

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Settings with the Effect of Isolating Individuals: Gated/Secured Community (aka “Intentional Communities”)

A gated/secured “community” for individuals with disabilities that has the following characteristics:

- The community typically consists primarily of individuals with disabilities and the staff that work with them
- Locations provide residential, behavioral health, day services, social and recreational activities, and long term services and supports all within the gated community
- Individuals often do not leave the grounds of the gated community in order to access activities or services in the broader community

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Settings with the Effect of Isolating Individuals: Residential Schools

Residential schools that have the following characteristics:

- The setting incorporates both the educational program and the residential program in the same building or in buildings in close proximity to each other so individuals do not travel into broader community
- Individuals served in the setting typically interact only with other residents of the home and the residential and educational staff
- Activities such as religious services are held on-site
- Individuals' experience with the broader community is limited to large group

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Settings with the Effect of Isolating Individuals: Multiple Settings Co-located and Operationally Related

Multiple settings co-located and operationally related (ie. operated and controlled by the same provider) which congregate a large number of people with disabilities together such that people's ability to interact with the broader community is limited

– Depending on the program design, examples include:

- Group homes on the grounds of a private ICF
- Numerous residential settings co-located on a single site or in close proximity, such as multiple units on the same street

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CMS: Provider Owned and Controlled

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

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Compliance Threshold

States are expected to assure 100% of HCBS settings meet the rules by March 17, 2019.

The Process for Transition So Far

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Iowa's Transition to the Transition

- January 2014 HCBS Rule Announced, with March 2014 effective date.
- Iowa began to analyze and train on the new rules
- Public Comments have been accepted 4 times since the rule began.
- Iowa submitted an updated statewide settings transition plan (STP) to CMS on April 1, 2016.

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Initial Approval

IOWA WAS GRANTED INITIAL APPROVAL OF THE STATEWIDE TRANSITION PLAN ON AUGUST 10, 2016

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Compliance Determination Overview

THERE WILL BE A COMPREHENSIVE, SITE-SPECIFIC ASSESSMENT OF ALL HCBS SETTINGS AND A WAY TO VALIDATE ASSESSMENT RESULTS:

- Self Assessment
- On-site Reviews
- Desk Reviews
- Participant Experience Surveys

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Rule Changes

Changes in rule are planned to be incorporated into Iowa Code during 2017

Where do you find information on rules that are proposed?
http://dhs.iowa.gov/administrative-rules

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Highlights from Iowa's Plan

Iowa's Transition Plan in Detail

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Non-Residential Settings:

Non-residential settings providing day activities should ensure that individuals have the opportunity to interact with the broader community of non-HCBS recipients and provide opportunities to participate in activities that are not solely designed for people with disabilities or HCBS members but rather for the broader community..

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Non-Residential Settings:

All settings that group or cluster individuals for the purposes of receiving HCBS must be assessed by the state for compliance with the rule.

This includes all group residential and non-residential settings, including but not limited to prevocational services, group supported employment and group day habilitation activities.

Non-residential exploratory questions:
https://dhs.iowa.gov/sites/default/files/exploratory_questions_non_residential.pdf

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Non-Residential Settings:

- IME has stated that they will visit all non-residential sites over the next 18 months to evaluate their compliance with the new standard.

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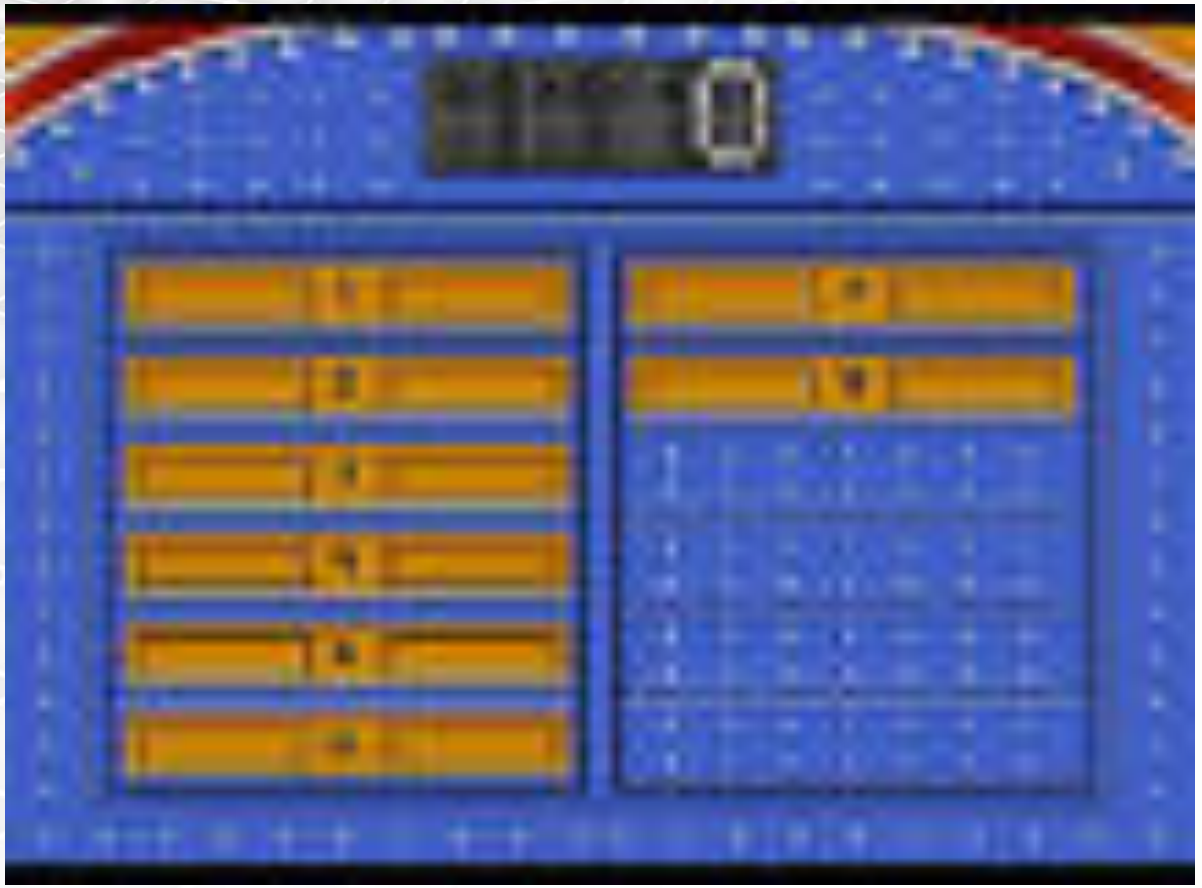
What about Reverse Integration?

CMS says….



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Reverse Integration

Reverse integration, or a model of intentionally inviting individuals not receiving HCBS into a facility-based setting to participate in activities with HCBS beneficiaries in the facility-based setting is not considered by CMS by itself to be a sufficient strategy for complying with the community integration requirements outlined in the HCBS settings rule.

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Reverse Integration

- States cannot comply with the rule simply by bringing individuals without disabilities from the community into a dis-allowed setting.
- Compliance requires a plan to integrate beneficiaries into the broader community.

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RESIDENTIAL SETTINGS

What about residential settings????

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.

Iowa is presuming that private, family homes meet the rule.

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Individual, Privately-Owned Homes

A state will generally not be required to verify this presumption. However, as with all settings, if the setting in question gives the appearance of being institutional in nature or of isolating a person and, the state determines that presumption is overcome, the state should submit to CMS necessary information for CMS to conduct a heightened scrutiny review

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Provider-Owned/Controlled Residential Settings

There will be additional checks in place to ensure compliance.

- What do your policies say?
- What is your practice to ensure rights, choice, individual direction?
- What is the experience of the member?

There must be evidence to support your assertions.

LINK RESIDENTIAL exploratory

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Facilities: RCFs

Any licensed facility in which an HCBS service is provided, will be evaluated to determine whether the setting should be subject to the heightened scrutiny process.

It is about the experience of the member.

Are they isolated from the community?

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DIA Conflicts Identified

- Possible conflicts with HCBS intent that have been identified in DIA rules:

  -discharge process may not offer protections equivalent to landlord tenant law,
  -choice of roommate may be limited in certain situations,
  -access to food at any time may be limited,
  -access to visitors may be limited,
  -daily schedules may be routinized.

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Site-Specific Remediation

- In the context of private residences, IME will make 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).

- It will also pertain to housing that is owned or operated by an agency.

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How Will Sites be Evaluated?

The state will have a strategy for implementing quality assurance checks in the process to verify setting compliance with respect to the HCBS rule is being conducted consistently throughout the state.

- Residential - Case managers will complete assessment that is currently in draft form. Draft version is based on the experience of the member.

- Provider owned and controlled - You need to be able to show policies and procedure that show you are addressing how members have control and choice.

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How Will Sites be Evaluated?

Iowa is focusing much of the survey on the Residential Exploratory Questions from CMS

Exploratory Questions for Residential Services
https://dhs.iowa.gov/sites/default/files/exploratory_questions_residential.pdf

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Heightened Scrutiny & Setting Non-Compliance

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Heightened Scrutiny: *When Should it be Applied?*

Heightened Scrutiny should only be applied if and when a state believes that a setting that falls into the category presumed not to be HCBS has overcome the presumption that a setting has institutional qualities or characteristics that isolate beneficiaries AND comports fully with the HCBS settings rule.

CMS Exploratory Questions:
https://dhs.iowa.gov/sites/default/files/exploratory_questions_residential.pdf

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Heightened Scrutiny Process

- If a state feels that a setting has overcome the presumption of institutional qualities or characteristics that isolate, AND that the setting either is in or can be brought into full compliance with the settings rule by March 2019, then the state may submit evidence to CMS demonstrating the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting

- Under the heightened scrutiny process, CMS reviews the evidence submitted by the state and makes a determination as to whether the evidence is sufficient to overcome the presumption

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Heightened Scrutiny: Public Notice

Public notice associated with settings for which the state is requesting HS should (continued):

- Include all justifications as to why the setting is home and community-based, and does not have institutional characteristics
- Provide sufficient detail such that the public has an opportunity to support or rebut the state's information
- State that the public has an opportunity to comment on the state's evidence
- CMS expects that states will provide responses to those public comments in the Statewide Transition Plan or submission to CMS

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HS Implementation with Integrity:
What additional information should states submit in the HS process?

Examples of additional documentation that a state may wish to include in its evidentiary package for a setting under HS could include:

- ✓ Observations from on-site review.
- ✓ Licensure requirements or other state regulations
- ✓ Residential housing or zoning requirements
- ✓ Proximity to/scope of interactions with community settings
- ✓ Provider qualifications for HCBS staff
- ✓ Service definitions that explicitly support setting requirements
- ✓ Evidence that setting complies with requirements of provider-owned or controlled settings
- ✓ Documentation in PCP that individual's preferences and interests are being met
- ✓ Evidence individual chose the setting among other options, including non-disability specific
- ✓ Details of proximity to public transport or other transportation strategies to facilitate integration
- ✓ Pictures of the site and other demonstrable evidence*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Communication with Members of Options when a Provider Will Not Be Compliant

If the setting is determined that it will not meet the integration setting standards IME will create a **detailed timeline and specific description** of how it will ensure that members are given the opportunity, the information and the supports to make an informed choice of an alternate setting that aligns with the federal requirements.

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Communication with Members of Options when a Provider Will Not Be Compliant

Based on the number of members that the state may need to relocate, they will make a member relocation plan and develop a timeline to accomplish this transition.

A description of how all members impacted by the need to access a compliant provider will receive reasonable notice and due process, including a minimum timeframe for that notice

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When a Setting Won't Comply

Members will be given the

opportunity,
information,
supports

to make an informed choice of an alternate setting that aligns with the federal requirements and have a process for ensuring how this transition will take place.

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When a Setting Won't Comply

The state will ensure that all critical services and supports are in place in advance of each individual's transition

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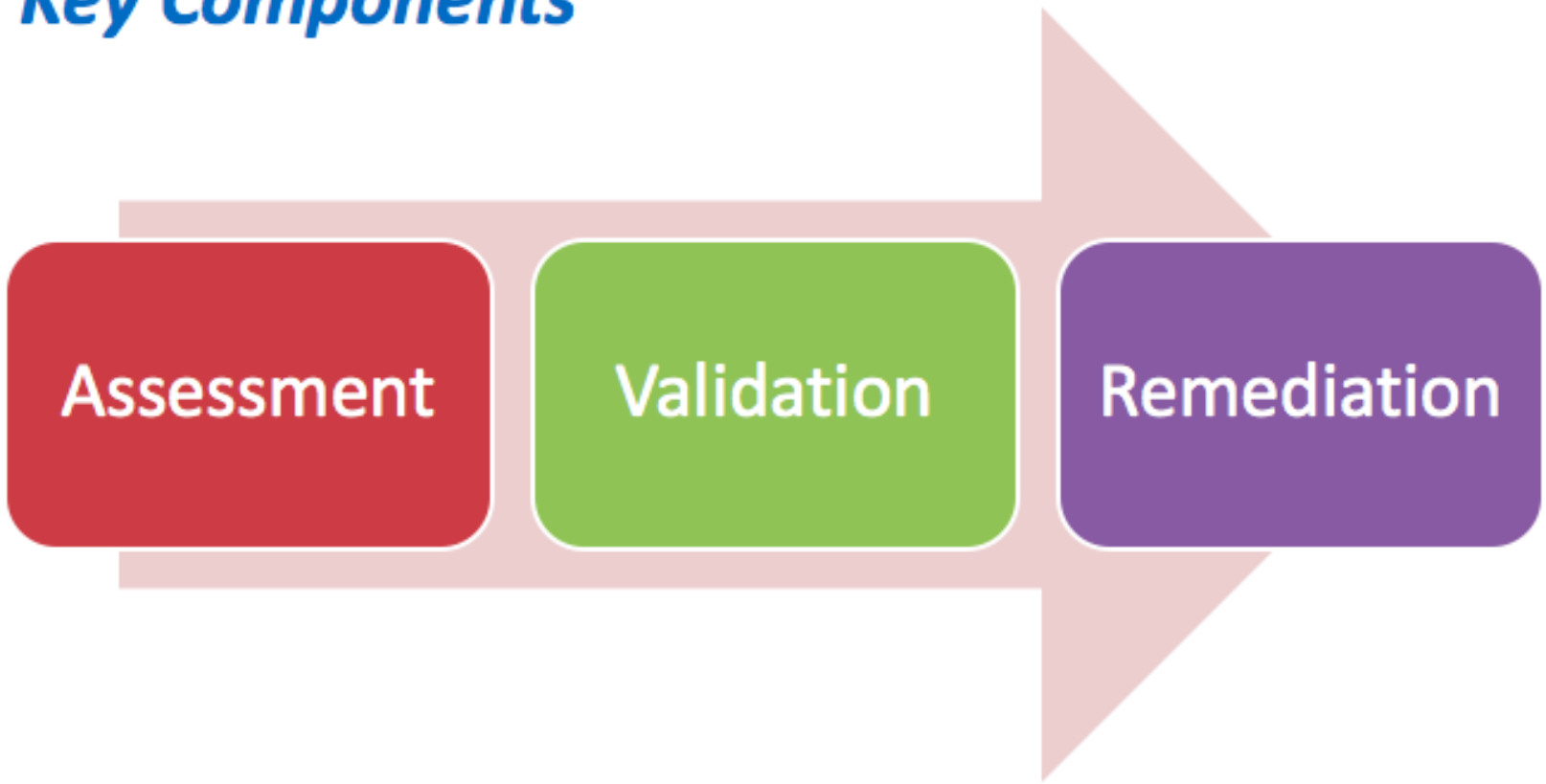
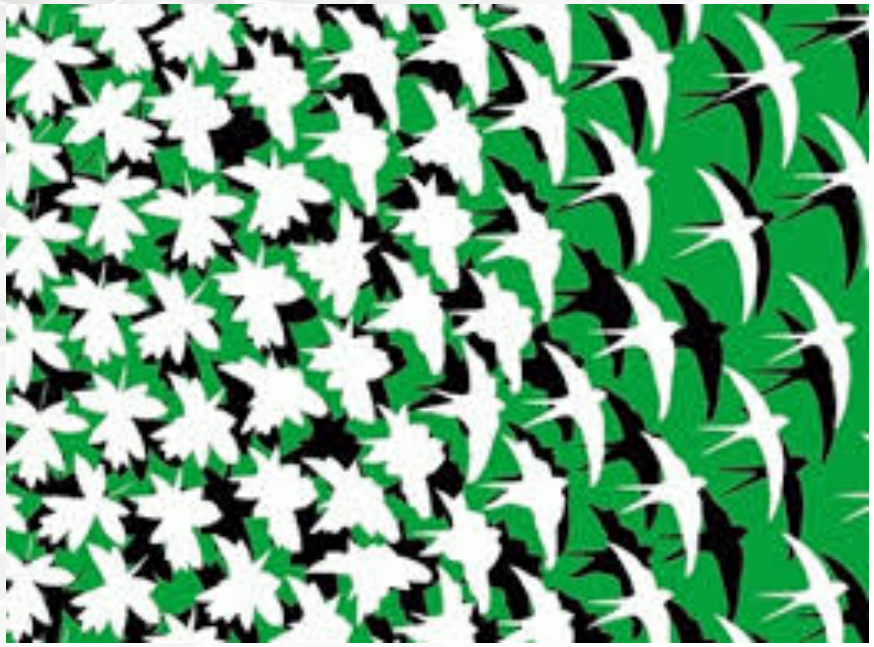
Review of HCBS Settings under Final Rule:
Key Components



State Quality Assurance

The state will educate providers on any changes in state standards that will require providers to make specific adjustments or modifications in order to comply with the federal HCBS rule.



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How Do You Know If Your Setting Will Comply: Iowa's Assessment and Validation Process

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Iowa's Test for Settings: Overview

The setting:

- is selected by the individual from options that include non-disability specific settings.
- optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom they interact.
- ensures the individual right of privacy, dignity and respect, and freedom from coercion and restraint.

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Provider owned or controlled residential settings

Lease/residency agreements:

At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.

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Iowa's Assessment and Validation Process

The department is taking a multifaceted approach to the assessment of HCBS settings. This includes a systematic review of the State's rules and policies and a high-level settings analysis:

- IPES (Iowa Participant Experience Survey)
- Self Assessment
- On-Site Review
- Case manager Assessments of settings (this tools is not yet complete)

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Iowa Participant Experience Survey (IPES)

- Monitoring of The IPES is conducted by HCBS Specialists from the HCBS Quality Assurance unit at the IME.

- Contact is made with the member's case manager prior to completion of the survey, and with the member at the time of scheduling, both of which provide opportunities to alert the HCBS Specialist of any assistance or accommodations that may be needed.

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Iowa Participant Experience Survey (IPES)

- The IPES interview is conducted in-person or by phone at the place and time of the member's choosing. If the member is unable to participate, a family member can be designated to respond on behalf of the member, however member participation is strongly encouraged

- The IPES files (MS Word documents) are available on the department website at: http://dhs.iowa.gov/sites/default/files/IPES%20Tools.zip

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Iowa Participant Experience Survey (IPES)

The questions on the IPES mirror the 20 outcomes.
Ex:

- Do you feel you get to choose the things you want to do in your life?
- Do you feel you have been a part of planning your services?
- Did you decide to use this/these service providers?
- If you didn't pick your providers, who did?
- Have you had to change a service provider or agency that you were working with? Why?
- Do you feel you understand your rights?

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Iowa Participant Experience Survey (IPES)

This was taken from last years survey:

The preliminary IPES results indicate that the majority of members receiving HCBS feel that they have choice in the direction of their lives and in the services and providers they use. Results also indicate that a large majority of members feel that they know their rights and that their rights are respected.

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Provider Self-Assessment

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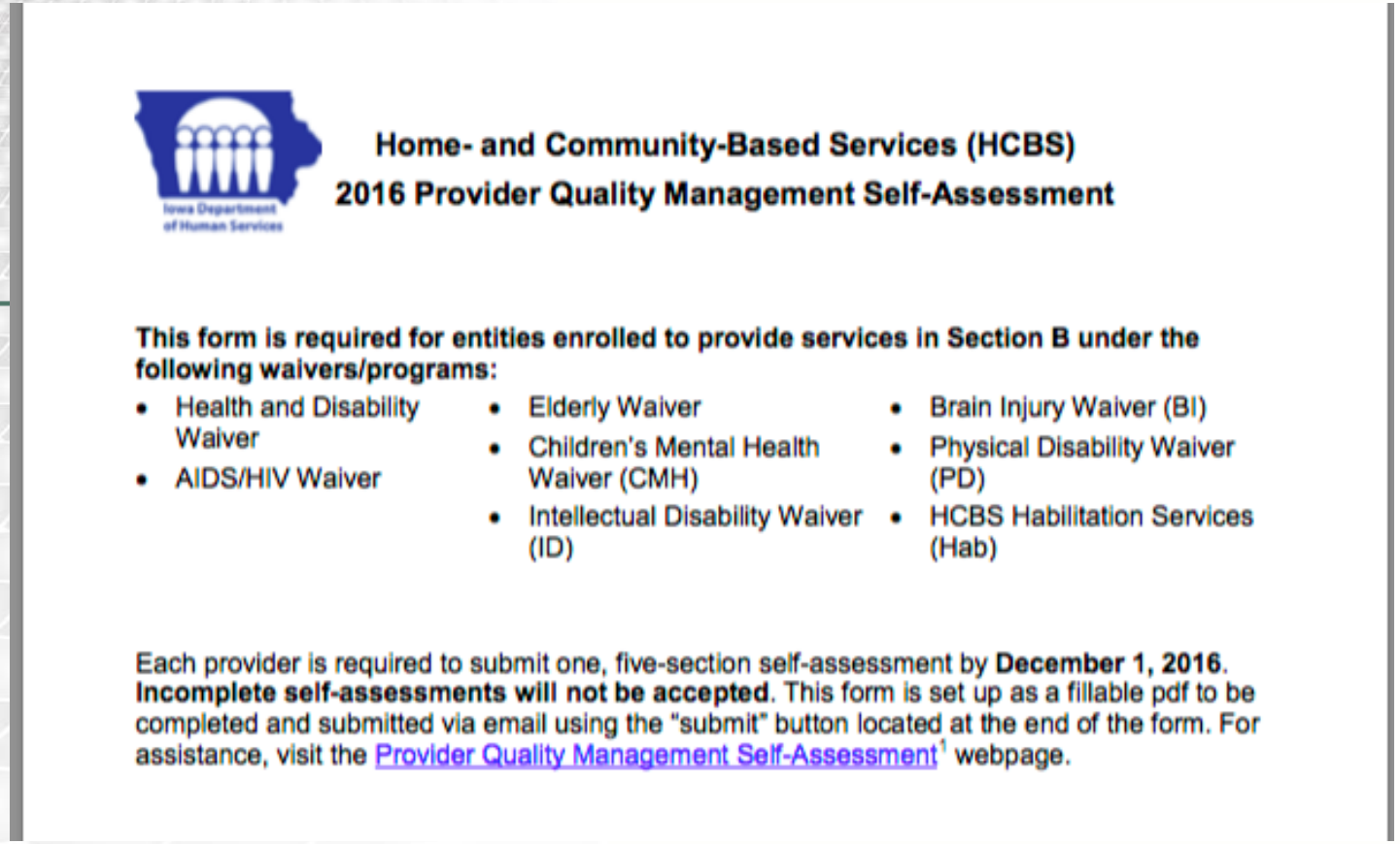
2016 Provider Self Assessment



Home- and Community-Based Services (HCBS)
2016 Provider Quality Management Self-Assessment

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health and Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

Each provider is required to submit one, five-section self-assessment by **December 1, 2016**. **Incomplete self-assessments will not be accepted**. This form is set up as a fillable pdf to be completed and submitted via email using the "submit" button located at the end of the form. For assistance, visit the Provider Quality Management Self-Assessment[1] webpage.

- The provider self-assessment will still serve as a starting point, but new assessment activities have been added to the plan. Additional assessments will be completed by the IME HCBS Quality Oversight Unit and by community-based case managers working through the state-contracted MCOs.

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Self-Assessment

- The self-assessment has been released to providers annually and is due back to their specialist on December 1.
- If a provider does not submit the self- assessment, the HCBS Quality Assurance unit will make a follow-up contact to attempt to obtain the self-assessment.
- If the provider still does not comply, a referral will be made to the IME Program Integrity unit. The Program Integrity unit may sanction the provider as allowed under Iowa Administrative Code 441— 79.2.

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Self Assessment Links

https://dhs.iowa.gov/sites/default/files/470-4547.pdf

Provider SA Website:
https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

IL: https://dhs.iowa.gov/sites/default/files/1729-MC-FFS_2016ProviderQualityManagementSelf-Assessment.pdf

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Validation of Provider Self-Assessments

- States must provide a validity check for provider self-assessments.
- States may deploy a number of validation strategies, including but not limited to:
  - – onsite visits by state staff, case managers or licensure/certification entities,
  - –consumer feedback, external stakeholder engagement,
  - –state review of data from operational entities, like MCOs or regional boards/entities.

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On-Site Assessment and Review

- Settings compliance is assessed during all reviews by the HCBS Quality Oversight Unit. This will ***also*** be done by the MCOs.
- In addition to the normal scheduled reviews, HCBS specialists will perform focused reviews of non-residential HCBS providers. Providers will be randomly selected based on a statistically valid sample of members taken at the 95% confidence level.
- *During the onsite review, the HCBS Specialist validates the provider's responses from the self-assessment.*

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Indicators of Compliance

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Indicators: What We Need to Show

Members receive most of their services in a setting that supports access to, and facilitates integration with the greater community within and outside the setting.

- Evidence: Quality Assurance plan including QA activities to measure ongoing remediation and improvement on settings requirements, member/stakeholder experience interviews, member preference/ needs assessment from service plan, daily service documentation

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Indicators: What We Need to Show

Services provide choices and options to optimize autonomy in the member's daily routine.

- Evidence: Member input in choice in time, location, type, and duration of services; service plan, IDT meeting minutes, member/ stakeholder experience interviews, daily service documentation, staffing schedules

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Indicators: What We Need to Show

Setting provides opportunities for meaningful and purposeful activities which facilitate personal growth and maintenance of skills, abilities, and desires.

- Evidence: Member needs assessments, daily service documentation, service plan, member/stakeholder experience interviews, monthly or quarterly summary, IDT meeting minutes

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Indicators: What We Need to Show

Members have the opportunity and support to access and manage personal resources.

- Evidence: Member needs assessments, daily service documentation, service plan, member/stakeholder experience interviews, monthly or quarterly summary, IDT meeting minutes, receipts or spending ledgers, bills, leases, location of personal resources in member's home, personal budgets

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Indicators: What We Need to Show

- Following is a guide developed for staff to use to help self-test these items. You may want to develop such a tool for your agency

- http://www.iowaproviders.org/technical_assistance/technical_assistance_docs/Community Living checklist.xlsx

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Iowa's Plan

- Assessment of compliance will remain as a part of the state's ongoing quality assurance process through the end of 2018.

- During the onsite review, the HCBS Specialist validates the provider's responses from the most recent self-assessment. Any standards that are found to be deficient require a corrective action plan (CAP)

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Quality Oversight Process

- HCBS uses a quality oversight process of discovery, remediation and improvement to assure compliance with all rules of the HCBS waiver and Habilitation programs.

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Quality Oversight Process

- When a compliance issue is identified, the provider is required to develop a corrective action plan (CAP) to address the issue. The CAP is submitted to the HCBS QOU (Quality Oversight Unit) for review and acceptance.

- Once a plan is accepted, a compliance review is scheduled and conducted within 60 days to assure that the activities identified in the CAP are being implemented.

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Quality Oversight Process

- The IME HCBS QOU is the single entity that is responsible for quality oversight of the HCBS setting implementation. While there may be multiple entities that will be responsible for gathering data, such as community based case managers, the IME HCBS QOU is responsible for quality assurance activities for the department.

- Providers that demonstrate compliance will be identified and ongoing quality monitoring activities are implemented for continued compliance.

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Quality Oversight Process

- Providers unable to develop and implement an acceptable CAP to address the specific issues may have sanctions imposed ***up to and including termination from the Medicaid program.***

- Any adverse action taken by the HCBS QOU may be appealed by a provider.

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Geography….

- Providers will be submitting lists of service locations as part of the self assessment process.
- The HCBS locations list that providers submitted as part of the Self Assessment process will be utilized to compare HCBS site locations with licensed institution locations.
- These are the facilities licensed by DIA.

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Geography….

- The State will explore potential settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

- The state will compare street addresses of HCBS sites to those of licensed hospitals, ICF/IDs, and nursing facilities/skilled nursing facilities.

- Because many assisted living sites provide HCBS, the state will also compare addresses of licensed assisted living sites of more than 5 beds with addresses of nursing facilities to determine if any are located in the same building.

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Geography….

- They will explore potential settings that are located in a building on the grounds of or immediately adjacent to a public institution, such as the the two state-run ICF/ID facilities (Woodward Resource Center and Glenwood Resource Center) and the two state-run psychiatric hospitals (Cherokee Mental Health Institute and Independence Mental Health Institute), which are the only institutions in the state that appear to fall under the public institution definition noted above.

- Addresses that are a close match but are not exact will be mapped to determine if they are adjacent.

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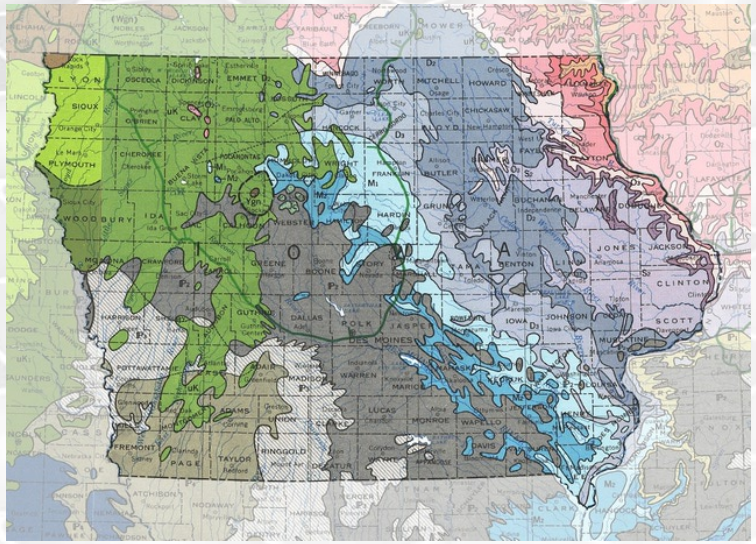
Geography….

The state will do onsite assessments at each identified location. These assessments will be performed by the IME HCBS Quality Oversight Unit or by MCO Community-Based Case Managers. The results of the on-site assessment will be reviewed by state HCBS policy staff who will determine whether or not the setting has the qualities of HCBS.



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Provider Sanctions

The state will sanction providers that have failed to comply with the settings regulation. This will include providers who:

- Refuse to cooperate with any assessment or remediation activities outlined in this transition plan
- Failing to correct any deficiency related to the settings regulation after receiving notice from the IME. This includes but is not limited to providers who fail to submit a CAP, fail to remediate deficiencies in a timely manner as described in the CAP, or fail to remediate all identified deficiencies as described in the CAP.

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Provider Sanctions

Possible sanctions include:

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

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Resources

Iowa Transition Plan Webpages:
http://dhs.iowa.gov/ime/about/initiatives/HCBS

Actual Transition Plan (April 2016):
https://dhs.iowa.gov/sites/default/files/HCBS_Settings_Statewide_Plan_April_2016.pdf

CMS Letter to Medicaid Director Stiers:
https://dhs.iowa.gov/sites/default/files/STP_Approval_Letter.pdf

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Resources

Person-Centered Planning
http://creativeoptionsregina.ca/being-person-cd

Dr. Serena Lowe - Administration for Community Living

Person-Centered Planning UM e-zine:
https://ici.umn.edu/products/impact/292/ezine/

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QUESTIONS

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