

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 - AIDS/HIV
 - C. **Waiver Number:** IA.0213
Original Base Waiver Number: IA.0213.
 - D. **Amendment Number:**
 - E. **Proposed Effective Date:** (mm/dd/yy)

05/01/16

- Approved Effective Date of Waiver being Amended:** 07/01/15

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
 Effective May 4, 2016 the department intends to begin utilizing the InterRAI or other department approved standardized assessment tool for the purposes of level of care determination and service planning for the HCBS AIDS/HIV waivers. The InterRAI will be completed initially by the member's MCO and again during the annual level of care review.

The department is changing to the InterRAI standardized assessment tool as the current process of the physician, doctor of osteopathy, registered nurse practitioner, or physician assistant completing the Level of Care Certification for HCBS Waiver Program Form 470-4392, and a service worker completing the Service Worker Comprehensive Assessment, Form 470-5044 is not a valid and standardized process for assessing level of care across a population.

The adoption of a standardized comprehensive functional assessment tool is specified in Iowa's application for enhanced federal Medicaid funding under the federal Balancing Incentive Payment Program (BIPP, established by Pub. L. No. 111-148, § 10202) which was submitted pursuant to the state legislature's direction in 2012 Iowa Acts, ch. 1133 (S.F. 2336), § 14.

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)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B-6
<input type="checkbox"/> Appendix C – Participant Services	
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	D-1
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

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

Specify:

The department intends to begin using the InterRAI standardized assessment tool for the purposes of level of care determination and service planning for this waiver population.

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 - AIDS/HIV

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.0213

Draft ID: IA.015.05.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/15

Approved Effective Date of Waiver being Amended: 07/01/15

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 in 42 CFR §440.160

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:

Iowa High Quality Healthcare Initiative (Submitted)

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 Eligibility 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.

Amendment Summary

This §1915(c) amendment is being submitted concurrently with a §1915(b) waiver application to implement the Iowa High Quality Healthcare Initiative (the "Initiative"). Specific authorities requested will allow the State to require the majority of

Medicaid beneficiaries to receive their nursing facility, hospice, home and community based services (HCBS) and physical and behavioral health services through managed care organizations (MCOs) selected by the State through a competitive procurement process.

The State will contract with a minimum of two, and not more than four, MCOs thereby ensuring members have the choice between entities. Further, members will receive choice counseling from an Enrollment Broker to assist in plan selection. Once a member is enrolled with an MCO he or she will have access to the State's Fair Hearing process, after exhausting the MCO's appeals system. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. Additionally, the State will have an Independent Advocate or Ombudsman services available to members to assist with understanding rights, responsibilities and handling of disputes and grievances. MCOs will be responsible for critical incident reporting and management in accordance with State requirements, as well as convening a Stakeholder Advisory Board to engage consumers, their representatives, and providers. The State will ensure compliance with all managed care regulations set forth in 42 CFR §438, unless otherwise waived, and that capitation rates are developed and certified as actuarially sound, pursuant to 42 CFR §438.6.

Certain waiver participants, as described in the §1915(b) waiver will not be eligible for managed care and will therefore continue to receive services through a fee-for-service delivery system. Participants ineligible for managed care will receive services through those processes currently in place for HCBS services, whereby the State is responsible for service plan development, care management, provider network management, utilization management, reimbursement of providers, quality oversight, etc.

Given the two distinct delivery systems under which this waiver will operate, this waiver narrative will refer to beneficiaries as: (1) "members," in the case of those being served by a managed care organization; or (2) "fee-for-service participants," in the case of those being served by the State. In those instances where the State provides a service or function on behalf of all beneficiaries regardless of delivery system, the waiver narrative will refer to "participants," generally. Further, MCOs will be required to adhere to all state policies, procedures, and regulations regarding waiver services including, but not limited to, responses provided in this waiver application.

Waiver Program Summary

The goal of the Iowa HCBS HIV/AIDS waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants 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 waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet hospital (as defined in 42 CFR §440.10) or nursing facility (as defined in 42 CFR §440.40 and 42 CFR §440.155) level of care. IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care reevaluations for fee-for-service participants. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

If the applicant is deemed eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the individual will have the option to choose between various traditional and self-directed services.

Services include adult day care, consumer directed attendant care, counseling, home delivered meals, home health aide, homemaker, nursing, respite, financial management services, independent support broker, self directed personal care, self-directed community and employment support and individual directed goods and services will be available for the individuals who chose to self-direct their services.

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 offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

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 6-1 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: Given character limitations within the CMS Waiver Management System, a summary of the State's public comment process and any waiver edits has been included in the Main Module, 8.B, "Additional Needed Information (Optional)." This information is also available online at <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>. In addition, DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Iowa Developmental Disability Council meets bi-monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues. Further, the public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council.
- 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:

Oudekerk

First Name:

Sally

Title:

Program Manager

Agency:

Address: Iowa Department of Human Services/Iowa Medicaid Enterprise

Address: 100 Army Post Road

Address 2:

City: Des Moines

State: Iowa

Zip: 50315

Phone: (515) 256-4643 Ext: TTY

Fax: (515) 256-4626

E-mail: soudeke@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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Iowa

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

The submitted amendment seeks to implement a managed care delivery system concurrent with the State's §1915(b) Iowa High Quality Healthcare Initiative waiver. All HCBS enrollees, regardless of delivery system, will be afforded the same services, rights, and safeguards as they are today. The primary difference between the approved waiver and the submitted amendment is the delineation of responsibility between the State and contracted MCOs, as the State has explicitly proscribed the manner in which services shall be provided to enrollees. The State will maintain responsibility for all enrollee level of care determinations. There are no limitations on the amount of waiver services in the proposed waiver that did not exist in the approved waiver.

Participants will be notified of delivery system changes through a comprehensive statewide communications strategy and will be provided enrollment assistance through a variety of means including by phone, in writing, or through an authorized representative. In addition, the state has developed partnerships with advocacy organizations (e.g., Area Agencies on Aging) to assist beneficiaries with enrollment and these organizations will also provide on-site assistance. In-person assistance by the State will be provided for beneficiaries with special healthcare needs who are unable to avail themselves of the traditional resources.

Procedures for offering participants an opportunity to request a fair hearing are outlined in significant detail in Appendix F-1 of the submitted amendment. In addition, the Iowa Department on Aging (IDA) is responsible for operating the Office of the State Long-Term Care Ombudsman (OSLTCO) which, in addition to advocating for residents of nursing facilities, residential care facilities, and tenants of assisted living programs and elder group homes, will utilize its resources to provide assistance and advocacy services to eligible recipients, or the families or legal representatives of such eligible recipients, of long-term services and supports provided through the Medicaid program.

OSLTCO assistance and advocacy includes but is not limited to: (1) assisting recipients in understanding the services, coverage, and access provisions and their rights under Medicaid managed care; (2) developing procedures for the tracking and reporting of the outcomes of individual requests for assistance, the obtaining of necessary services and supports, and other aspects of the services provided to eligible recipients; and (3) providing advice and assistance relating to the preparation and filing of complaints, grievances, and appeals of complaints or grievances, including through processes available under managed care plans and the state appeals process, relating to long-term services and supports under the Medicaid program.

Finally, Section 8.15.1 Iowa's MCO Contracts, Special Terms Appendix 1 – Scope of Work requires MCOs to “inform members of their grievance, appeal, and State fair hearing rights in member enrollment materials,” and to direct all member eligibility and eligibility related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities to the State.

Contract performance will be monitored by a state employed contract manager assigned to the MCO. Contract managers are responsible for ensuring that the MCO meets its contractual obligations within the stated timeframes. Regarding grievances, each MCO is contractually required to resolve one hundred percent of grievances within thirty calendar days of receipt, or within three business days of receipt for expedited grievances. The MCO must also maintain and report to the State a member grievance log that includes the current status of all grievances. Regarding appeals, each MCO is contractually required to resolve one hundred percent of appeals within forty-five calendar days of receipt, or within three business days of receipt for expedited appeals. One hundred percent of appeals must be acknowledged within three business days. Each MCO must maintain and report to the State a member appeal log that includes the current status of all

appeals.

Statewide MCO enrollment in the Initiative will be effective April 1, 2016. As such, the State will begin accepting MCO selections from current Medicaid enrollees beginning in fall 2015. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) deal the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The Enrollment Broker will take MCO selections and provide choice counseling to assist enrollees. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To permit additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915i home and community based services under the Iowa Medicaid State Plan.

Those participants who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through fee-for-service delivery system.

Within five (5) business days of receipt of member enrollment information, MCOs will distribute enrollment materials to each member. All information will be provided to members with limited English proficiency through the provision of language services at no cost to the individual. All written materials will be provided in English and Spanish, and any additional prevalent languages identified by the State, and will be made available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., 508 compliance, Braille, large font, audiotape and verbal explanations of written materials). All members and potential members will be informed that information is available in alternative formats and how to access those formats.

Enrollment materials will include, but not be limited to, provider directory information and/or information on how to find a network provider near the member's residence, the MCO's contact information, the amount, duration, and scope of covered services, information regarding the availability of Member Helpline and 24-hour Nurse Call Line, procedures for obtaining benefits, a description of any restrictions on the member's freedom of choice among network providers, and information on the grievance and appeal process. Specific information regarding waiver services will include a description of the community-based case management's or integrated health home's role and responsibilities, information on how to change community based case management or integrated health homes, and when applicable, information on the option to self-direct.

For those participants transitioning from fee-for-service to managed care, MCOs will implement a comprehensive strategy, subject to State approval, to ensure a seamless transition of services during program implementation. Strategies will include timelines within which all members receiving 1915(c) waiver services will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services will not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination.

MCOs will also ensure that members are permitted to see all current providers on their approved service plan upon initial enrollment, even on a non-network basis, until a service plan is completed and agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. MCOs will extend the authorization of waiver services from a non-network provider as necessary to ensure continuity of care pending the provider's contracting with the MCO, or the member's transition to an in-network provider. MCOs will be responsible for facilitating a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the MCO without any disruption in services. Further, MCOs are contractually required to extend DHS enrolled 1915(c) HCBS waiver providers an opportunity to be part of its provider network.

MCOs will implement plans, subject to State approval, to provide seamless, effective transition from the member's former targeted case manager, case manager, or service worker (as applicable), and any change in community-based case management. MCOs will allow members to retain their current case manager during the first six months of transition. All transition plans will be fully implemented within one year.

DHS will provide data sharing with MCOs to assist in continuity of care, including providing prior authorizations in place at the time of member transition, claims history and service plans. Further, DHS will implement oversight strategies to ensure MCO compliance with continuity of care requirements, including, but not limited to, readiness review and regular reporting.

DHS and the MCOs will also implement strategies to assist providers in the transition. DHS strategies will include educational sessions and the provision of written materials such as frequently asked questions and provider bulletins. MCOs are contractually required to implement provider communication strategies which will assist in provider transition such as publication of a provider manual, maintenance of a provider website, operation of a provider services helpline, and extensive provider training.

DHS and the MCOs will also implement a comprehensive member and stakeholder education and engagement strategy to assist in transition, ensure understanding of the program and promote a collaborative effort to enhance the delivery of high quality services to members. DHS operates an Managed Long Term Services and Supports (MLTSS) Advisory Group for long-term services and supports recipients and stakeholders. Further, the MCOs are contractually required to operate a Stakeholder Advisory Board which is charged with providing input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

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.

Iowa assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Section I: Assessment Milestones

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver participants.

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 and MCOs 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 and MCOs 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 and MCOs 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 through 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 and MCOs 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

Process:

Public comment was taken from March 4, 2015 through April 3, 2015. The transition plan was posted on the IME website at: <https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans>. The transition plan has been available at that location since December 31, 2014. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on February 26, 2015. The transition plan was available for non-electronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally-recognized tribes on February 26, 2015.

Summary of Comments:

Comments that resulted in changes to the transition plan:

There were no comments received that resulted in changes to the transition plan.

Comments for which the State declined to make changes to the transition plan or settings analysis document:

There were numerous comments submitted which did not ask for changes to the transition plan, but rather were seeking clarification or interpretation of the federal regulation or posed operational questions about how the state would carry out activities in the transition plan.

Four commenters suggested that various aspects of the transition plan need to be updated to reflect the role that the Managed Care Organizations (MCOs) will have related to the Iowa High Quality Health Care Initiative. The state declined to make changes based on the comment and explained in the response that Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future, and that there will be another public comment period related to those amendments at that time.

Two commenters expressed concern about engaging consumers, families and advocates in the transition plan. The state declined to make changes based on the comment and explained the various ways that input from consumers and advocates has been sought in the development of the plan and expressed that consumer and advocate involvement will continue throughout implementation.

One commenter suggested that the "players" column which existed in an early draft of the transition plan, but was later removed should be added back into the plan. The state declined to make this change and explained in the response that the responsibility for completion of the activities listed in the transition plan lies with the IME, and other stakeholders are already noted in the description column for each item or in the explanatory narrative at the top of each section.

One commenter expressed that activities within the transition plan should not have end dates listed as "ongoing". The state declined to make this change and explained in the response that our approach utilizes an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline, and our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis.

One commenter suggested that the actions or omissions that would trigger the requirement of a corrective action plan (CAP) should be listed in the transition plan. The state declined to make this change, explaining that any finding of noncompliance will trigger a CAP.

One commenter suggested that in regard to provider remediation, rather than the State allowing "reasonable time frames" for large infrastructure changes, the State should impose specific timeframes and deadlines. The state declined to make a

change because we believe the commenter misunderstood the intent of the item. Our response to the comment explained that the timeframes that will be set out in any given CAP will be specific deadlines for that provider and location. The “reasonable timeframes” language needs to be read in the context of the previous sentence in the plan which indicates that in reviewing a CAP, the state will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Iowa High Quality Healthcare Initiative
Public Comment Summary

I. Background

The Iowa Department of Human Services (DHS) has continually sought to improve Medicaid and the Children’s Health Insurance Program (CHIP) and beneficiary choice, accountability, quality of care, and health outcomes. DHS has also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative). In recent months, this Initiative has also been referred to publicly as the Governor’s “Medicaid Modernization Initiative.”

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the Initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). MCOs are private health care organizations that provide and pay for health care services through an organized network of providers. MCOs use established guidelines to assure member services are appropriate and delivered at the right time, in the right way, and in the right setting. By contracting with MCOs for delivery of high quality health care services, beneficiaries’ care will be better coordinated, resulting in improved access, quality, and health outcomes.

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (<http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback.

II. Federal Authorities

DHS is working with the Centers for Medicare and Medicaid Services (CMS) to obtain the necessary federal authority to implement the Initiative. This requires submission of a variety of federal Medicaid waivers and amendments, noted below.

§1915(b) Iowa High Quality Healthcare Initiative Waiver (New Waiver)
 §1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
 §1915(c) HCBS Children’s Mental Health Waiver (Amendment)
 §1915(c) HCBS Elderly Waiver (Amendment)
 §1915(c) HCBS Health & Disability Waiver (Amendment)
 §1915(c) HCBS Physical Disability Waiver (Amendment)
 §1915(c) HCBS Brain Injury Waiver (Amendment)
 §1915(c) HCBS AIDS/HIV Waiver (Amendment)
 §1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
 §1115 Family Planning Demonstration Waiver (Amendment)

Prior to submission of the aforementioned waivers, the State elected to conduct a public notice and comment process. At the beginning of this process, four of the State’s §1915(c) waivers were pending review by CMS for matters unrelated to the Initiative. As such, the State has broken down the process into three “phases.” However, managed care elements were

consistent across all §1915(c) waivers. Notices, waiver documents, and information about the Initiative were posted online, and non-electronic copies were made available for review at DHS Field Offices, for each “phase.” In addition, a summary notice was published in several newspapers with statewide circulation. The notice provided the option for any individual to submit written feedback to the State by email or by USPS mail.

Phase 3

Public notice for Phase 3 was provided on August 21, 2015, and included: (1) §1915(c) HCBS Brain Injury Waiver (Amendment); (2) §1915(c) HCBS AIDS/HIV Waiver (Amendment). Hearings were not held for the Phase 3 public comment period, as managed care descriptions for the waivers included in the published waivers (e.g., MCO roles and responsibilities) were the same as those published in Phase 1 and 2. Phase 3 ended on September 25, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Tribal Consultation

The State also consulted with Iowa’s federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of the waivers. Consultation was conducted in accordance with the process outlined in the State’s approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. This notice was provided concurrently with notice of each phase described above and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions.

I. Public Comments – Phase 3

Three comments (written) were received between the end of Phase 2 and the end of Phase 3. Two comments were waiver specific, and the remaining comment targeted the Initiative in general. Comments addressed service delivery/access, home and community based services, and outreach.

a. Service Delivery/Access

One comment was received related to service delivery/access. The commenter expressed concern that providers would not enroll with the selected MCOs, and requested that all HCBS waivers be carved out of the Initiative.

Brain Injury and AIDS Waiver Specific Comments:

Two comments were received related to service delivery/access. One commenter asked if it was the State’s intention to eliminate payments to legally responsible individuals furnishing personal care services to HCBS enrollees. The commenter noted that this option was currently available under other State approved HCBS waivers, as well as the published Intellectual Disability, Elderly, Health & Disability, and Physical Disability waiver amendments; however, the option was not permitted in the published Brain Injury and AIDS waiver amendments. Another commenter expressed concern that the current waiver language may restrict physician assistants’ practice. Specifically, the commenter suggested that use of “physician only” terminology might lead to the impression that only physicians may perform certain tasks (e.g., physicians order Interim Medical Monitoring and Treatment, physicians diagnose AIDS/HIV, physicians participate in a level of care determination, etc.).

State Response:

As noted in the State’s Phase 1 and 2 responses to similar comments, the Initiative strives to support and increase HCBS provider access. As such, MCOs will be held accountable for meeting contractual requirements for HCBS access standards and must authorize out-of-network care when it cannot be provided in-network.

It was not the State’s intention to eliminate payments to legally responsible individuals furnishing personal care services to any HCBS enrollee, regardless of waiver. Not only is this an option that enrollees and advocates have championed in the past, it is provided for in 441 Iowa Administrative Code 79.9(7)(b), which states: “medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or

younger.” Removal of this option was a technical mistake in the published application, and has been corrected in the final application submitted to CMS.

Finally, the State recognizes the invaluable role of physician assistants as providers of patient-centered, team-based medical care. State laws and regulations (e.g., Iowa Code §148C, and 645 Iowa Administrative Code Chapters 326 – 329) generally set forth the scope of practice for physician assistants, and the waiver amendments do not modify existing program requirements. As such, no changes have been made to the waivers as a result of these comments.

b. Outreach

Comments Received:

One comment was received related to member outreach. In general, the commenter felt the State should solicit greater stakeholder input in developing the Initiative and that members were unaware of the implications of the transition to managed care

State Response:

As noted in the State’s Phase 1 responses to similar comments, the State has been engaging stakeholders since the preliminary Request for Proposals (RFP) was released for the Initiative on February 16, 2015. The State will continue to work with member advocacy organizations to communicate the transition to members and to ensure they understand its impact. No changes have been made to the waivers as a result of this comment.

c. Tribal Consultation

No questions or comments were received regarding the Phase 3 waivers.