## 1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

**1. Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

HCBS Habilitation Services. 1915(i) HCBS State Plan Program

**2. Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

| | |
|---|---|
| ○ | **Not applicable** |
| X | **Applicable** |

Check the applicable authority or authorities:

| | |
|---|---|
| ☐ | **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*<br>*(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);*<br>*(b) the geographic areas served by these plans;*<br>*(c) the specific 1915(i) State plan HCBS furnished by these plans;*<br>*(d) how payments are made to the health plans; and*<br>*(e) whether the1915(a) contract has been submitted or previously approved.* |
| | |
| X | **Waiver(s) authorized under §1915(b) of the Act.**<br>*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 (Approved 2/23/16) |

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

| | | | |
|---|---|---|---|
| X | §1915(b)(1) (mandated enrollment to managed care) | X | §1915(b)(3) (employ cost savings to furnish additional services) |
| ☐ | §1915(b)(2) (central broker) | X | §1915(b)(4) (selective contracting/limit number of providers) |

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|---|---|
| ☐ | **A program operated under §1932(a) of the Act.**<br>*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 §1115 of the Act.** *Specify the program*: |
| | |

**3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

| | | | |
|---|---|---|---|
| X | The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*: | | |
| | X | The Medical Assistance Unit *(name of unit)*: | The Iowa Medicaid Enterprise |
| | ○ | Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.* | |
| ○ | The State plan HCBS benefit is operated by *(name of agency)* | | |
| | | | |
| | A separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request. | | |

**4. Distribution of State plan HCBS Operational and Administrative Functions.**

X *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity | Local Non-State Entity |
|---|---|---|---|---|
| 1 Individual State plan HCBS enrollment | ☑ | ☐ | ☑ | ☐ |
| 2 Eligibility evaluation | ☑ | ☐ | ☐ | ☐ |
| 3 Review of participant service plans | ☑ | ☐ | ☑ | ☐ |
| 4 Prior authorization of State plan HCBS | ☑ | ☐ | ☑ | ☐ |
| 5 Utilization management | ☑ | ☐ | ☑ | ☐ |
| 6 Qualified provider enrollment | ☑ | ☐ | ☑ | ☐ |
| 7 Execution of Medicaid provider agreement | ☑ | ☐ | ☐ | ☐ |
| 8 Establishment of a consistent rate methodology for each State plan HCBS | ☑ | ☐ | ☑ | ☐ |
| 9 Rules, policies, procedures, and information development governing the State plan HCBS benefit | ☑ | ☐ | ☑ | ☐ |
| 10 Quality assurance and quality improvement activities | ☑ | ☐ | ☑ | ☐ |

*(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):*

1. Individuals are assisted with enrolling in the state plan HCBS Habilitation services through the Iowa Medicaid Enterprise's Health Link managed care organizations (MCO), the case manager or integrated health home care coordinator.
2. The Department of Human Services' Income Maintenance Worker determines if the member is eligible for Medicaid and determines the member's income level.
3. The Iowa Medicaid Enterprise's Medical Services Unit determines if the member meets the needs based criteria also referred to as the non-financial criteria for enrollment in state plan HCBS. MCOs conduct initial assessments of needs based criteria for their enrolled membership; the Medical Services Unit maintains final review and approval authority.
4. Service plan review is carried out by the MCOs for Health Link enrollees. This function is also carried out by the Iowa Medicaid Enterprise's contractor for medical services or Policy staff for

individuals enrolled in fee-for-service.

5. Recommendation for prior authorization is done by the MCOs through the service plan review process for Health Link enrollees. This function is completed by Iowa Medicaid Enterprise policy staff for individuals enrolled in fee-for-service.
6. Utilization management functions are set by Iowa Medicaid Enterprise policy staff and are carried out by the MCOs for Health Link enrollees and the Iowa Medicaid Enterprise's contractor for medical services for fee-for-service enrollees. Needs-based eligibility criteria are determined by Iowa Medicaid Enterprise policy staff. The MCOs review the needs-based evaluation for their enrollees to ensure the member meets the need-based eligibility criteria; the Iowa Medicaid Enterprise Medical Services Unit maintains final review and approval authority. Parameters for prior authorization are determined by Iowa Medicaid Enterprise policy staff, MCO service authorization systems and the contractor for medical services review and authorize treatment plan data.
7. Recruitment of providers may be done by Iowa Medicaid Enterprise policy staff or by the MCOs.
8. Execution of the provider agreement is done by the Iowa Medicaid Enterprise and reinforced through the contractual agreements between the MCOs and the provider. The provider agreement has been written by the Iowa Medicaid Enterprise staff in conjunction with the Iowa Attorney General's office.
9. Establishment of a consistent rate is done by the Iowa Medicaid Enterprise for the fee-for-service reimbursement and by the MCOs with the participation by Iowa Medicaid Enterprise policy staff.
10. Training and technical assistance is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor. The MCOs and the Iowa Medicaid Enterprise policy staff also conduct training as needed.
11. Quality monitoring is overseen primarily by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor. The MCOs also maintain a quality assurance monitoring system for the Habilitation service provider network.

*(By checking the following boxes the State assures that):*

**5.** X **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Integrated Health Home Care Coordinator, MCO community-based case manager, or Targeted Case Manager completes the comprehensive functional assessment and then submits the assessment to the Iowa Medicaid Enterprise's Medical Services Unit contractor for needs-based criteria eligibility determination for state plan HCBS. The IME's Medical Services Unit also predetermines non-financial eligibility on an annual basis. Final determinations regarding eligibility, assessment, and person-centered services plans are made by the Iowa State Medicaid Agency.

**6.** X **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

**7.** X **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

**8.** X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

## Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
*(Specify for year one. Years 2-5 optional):*

| Annual Period | From | To | Projected Number of Participants |
|---|---|---|---|
| Year 1 | 07/01/2013 | 06/30/2014 | 5,318 |
| Year 2 | 07/01/2014 | 06/30/2015 | 5,716 |
| Year 3 | 07/01/2015 | 06/30/2016 | 6,143 |
| Year 4 | 07/01/2016 | 06/30/2017 | 6,602 |
| Year 5 | 07/01/2017 | 06/30/2018 | 7,095 |

2. X **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

## Financial Eligibility

1. X **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. ☐ **New 1915(i) Medicaid Eligibility Group.** In addition to providing State plan HCBS to individuals described in item 1 above, the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, pages ____ and ____ of the State Plan).

3. **Medically Needy** (*Select one*):

| |
|---|
| ☐ The State does not provide State plan HCBS to the medically needy. |
| X The State provides State plan HCBS to the medically needy. (*Select one*): |
| ☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, medically needy individuals receive only 1915(i) services.<br>X The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act. |

## Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

| | |
|---|---|
| ○ | Directly by the Medicaid agency |
| X | By Other (*specify State agency or entity under contract with the State Medicaid agency*): |
| | The Iowa Medicaid Enterprise provides financial eligibility data daily to the MCOs. A member requesting Habilitation services must be Medicaid eligible and have income that does not exceed 150% FPL.<br><br>The Comprehensive Functional Assessment to determine if the member meets the needs based criteria for services is completed by a Case Manager (CM), MCO community-based case manager, the Iowa Medicaid Enterprise's Medical Services Unit contractor, or an Integrated Health Home Coordinator (IHHCC).<br><br>The assessment is submitted to the Iowa Medicaid Enterprise's Medical Services Unit for approval of non-financial eligibility state plan HCBS. Iowa Medicaid Enterprise's Medical Services Unit contractor is responsible for annual approval.<br><br>If the member meets the criteria, Habilitation is approved and the MCO, CM or IHHCC are notified. The CM, MCO community-based case manager or IHHCC coordinates the interdisciplinary team meeting to develop the service plan. Once developed the service plan is submitted to the MCO for Health Link enrollees, or the Medical Services Unit for fee-for-service enrollees for service authorization.<br><br>This process is repeated annually or more often as the member's circumstances or situation dictates in order to determine continued eligibility and to reauthorize services.<br><br>The direct service provider submits the claim for service to the MCO for Health Link enrollees, or to the Iowa Medicaid Enterprise for payment for members not eligible for Health Link. |

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Individuals performing evaluations must:

- be a masters' level mental health professional;
- have a four-year health-related degree; or
- be a registered nurse licensed in the State of Iowa with a minimum of 2 years experience providing relevant services.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Comprehensive Functional Assessment Tool, as identified by DHS, is utilized to determine if an individual meets the needs-based criteria. For fee-for-service enrollees, this assessment is completed by the CM or IHHCC. This assessment is then reviewed by the Iowa Medicaid Enterprise's Medical Services Unit for final review and approval. For Health Link enrollees, MCO community-based case managers complete the assessment and submit it to the Medical Services Unit for final approval.

Re-evaluations for continued 1915(i) services follow this same process.

**4.** X **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

**5.** **X** **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The individual meets at least one of the following risk factors:

- Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals.
- Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- Shows severe inability to establish or maintain a personal social support system.
- Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- Exhibits inappropriate social behavior that results in demand for intervention.

**6.** X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

| State plan HCBS needs-based eligibility criteria | NF (& NF LOC** waivers) | ICF/IID (& ICF/IID LOC waivers) | Applicable Hospital* (& Hospital LOC waivers) |
|---|---|---|---|
| The individual meets at least one of the following risk factors:<br>▪ Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan | Based on the Minimum Data Set (MDS) section G, the individual requires supervision, or limited assistance provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living.<br><br>-OR-<br><br>Based on the MDS, the individual requires the establishment of a safe, secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required, never or rarely made a decision, danger to self or other) of cognitive skills for daily decision-making:<br>▪ Cognitive, mood and behavior patterns | 1. A diagnosis of intellectual disability before 18 years of age as defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) or a related condition as defined by the Code of Federal Regulations 41 CFR 435.1009.<br><br>--AND—<br><br>2. Three or more deficits resulting in substantial functional limitation in major life activity areas as defined in 42 CFR 45.1009(d):<br>▪ Self-care<br>▪ Understanding and use of language<br>▪ Mobility<br>▪ Self Direction<br>▪ Capacity for independent living | **Mental Status:**<br>A. Need for 24-hour professional observation, evaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder which may include significant mental status changes.<br>B. Documented failure of current outpatient treatment including two or more of the following necessitating 24 hour professional observation supported by medical record documentation:<br>▪ Exacerbation of symptoms<br>▪ Noncompliance with medication regimen<br>▪ Lack of therapeutic response to medication<br>▪ Acute neuroleptic reaction<br>▪ Psychotropic or neuroleptic medication toxicity<br>▪ Lack of patient participation in the outpatient treatment program<br><br>Information regarding prior hospitalizations and length of stay will be obtained as well as evaluation of the patient's medical stability to participate in a |

| | | | |
|---|---|---|---|
| Services while in an institution, including hospitals.<br>▪ Has a history of psychiatric illness resulting in at least one episode of continuous professional supportive care other than hospitalization.<br><br>-AND-<br><br>Has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:<br>▪ Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.<br>▪ Requires financial assistance | ▪ Physical functioning-Mobility<br>▪ Skin condition<br>▪ Pulmonary Status<br>▪ Continence<br>▪ Dressing and Personal Hygiene (ADLs)<br>▪ Nutrition<br>▪ Medications<br>▪ Communication<br>▪ Psycho-social | | comprehensive treatment plan. |

| | | | |
|---|---|---|---|
| for out-of-hospital maintenance and may be unable to procure this assistance without help.<br>▪ Shows severe inability to establish or maintain a personal social support system.<br>▪ Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.<br>▪ Exhibits inappropriate social behavior that results in demand for intervention. | | | |

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

*(By checking the following boxes the State assures that):*

**8.** X **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

**9.** X **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal HCB Settings requirements at 42 CFR 441.710(a)-(b) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal HCB Settings requirements, at the time of submission and in the future):*

*(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal HCB Setting requirements, at the time of this submission and ongoing.)*

All residential settings where Habilitation services are provided must document the following in the member's service or treatment plan:

a. The setting is integrated in, and facilitates the individual's full access 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, like individuals without disabilities;
b. The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
d. Individual initiative, autonomy and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
e. Individual choice regarding services and supports, and who provides them, is facilitated.

Residential settings that are provider owned or provider controlled or operated including licensed Residential Care Facilities (RCF) for 16 or fewer persons must document the following in the member's service or treatment plan:

a. The setting is integrated in, and facilitates the individual's full access 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, like individuals without disabilities;
b. The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
d. Individual initiative, autonomy and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;

e. Individual choice regarding services and supports, and who provides them, is facilitated;
f. Any modifications of the conditions (for example to address the safety needs of an individual with dementia) must be supported by a specific assessed need and documented in the person-centered services plan;
g. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
h. Each individual has privacy in their sleeping or living unknit.
i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;
j. Individuals sharing units have a choice of roommates in that setting;
k. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
l. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
m. Individuals are able to have visitors of their choosing at any time; and
n. The setting is physically accessible to the individual.

For 1915(i) State plan home and community-based services, settings that are not home and community-based are defined at §447.710(a)(2) as follows: A nursing facility, an institution for mental disease, an intermediate care facility for individuals with intellectual disabilities, a hospital, or any other locations that have qualities of institutional setting, as determined by the Secretary.

**Setting Requirements**

In accordance with the state's transition planning requirements to be effective on the date approved by CMS, Habilitation services may not be provided in settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment, on the grounds of, or immediately adjacent to, a public institutional; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

## Person-Centered Planning & Service Delivery

*(By checking the following boxes the state assures that):*

**1.** X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

**2.** X Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

**3.** X The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

**4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Educational/professional qualifications of individuals conducting assessments are as follows:

1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services, or
2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services, or
3. Licensed masters level mental health professional – LISW, LMHC or LMFT

**5. Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Individualized, person-centered plans of care will be developed by individuals with the following educational/professional qualifications:

1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services, or
2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services, or
3. Licensed masters level mental health professional – LISW, LMHC or LMFT

**6. Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

(a) The service plan or treatment plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager, integrated health home coordinator or MCO community-based case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team. The participant and the team identify the participant's strengths, needs, preferences desired outcomes, and his or her desires in order to determine the scope of services needed. The case manager, integrated health home care coordinator or MCO community-based case manager informs the participant of all available Medicaid and non-Medicaid services. The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals.

(b) The interdisciplinary team includes the participant, his or her legal representative if applicable, the case manager, integrated health home coordinator or MCO community-based case manager, and any other persons the participant chooses, which may include service providers. Individuals that are not Medicaid providers are not reimbursed for their participation.

(c) The Case Manager, Integrated Health Home Coordinator or MCO community-based case manager must ensure that the service planning process:

a. Occurs at times and locations convenient to the participant
b. Reflects cultural considerations of the individual
c. Includes strategies for solving conflict or disagreement within the process including clear conflict of interest guidelines for all planning participants
d. Includes a method for the individual to request updates to the plan
e. Records the alternative home and community based settings that were considered for the individual
f. Includes the goals related to community living
g. Includes risk factors and the measures in place to minimize them including individualized back up plans

(d) The plan is signed by all individuals and providers responsible for its implementation.

(e) The participant and others involved in the plan are provided a copy of the plan.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The case manager, MCO community-based case manager or integrated health home care coordinator informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the service plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with the available providers before choosing a provider.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

The Iowa Department of Human Services has developed a computer system named the Individualized Services Information System (ISIS) to support certain Medicaid programs. This system assists with tracking information and monitoring the service plan and enforces parameters

| |
|---|
| such as unit and rate caps set by the department.<br><br>For habilitation participants who are not enrolled with an MCO through Health Link, the habilitation case manager initiates a request for services through this system, and Iowa Medicaid Enterprise (IME) staff responds to the request for Habilitation. Case managers complete the assessment of the need for services and submit it to the IME Medical Services Unit for evaluation of program eligibility. The case manager is also responsible for entering the service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into ISIS, where it is reviewed for authorization by IME Medical Services staff.<br><br>For habilitation participants who are enrolled in Health Link, the MCOs have established a process, which is subject to State review and approval, for reviewing treatment plans and authorizing units of services. A determination is made by the MCO for the appropriate services and units based on the assessment, treatment plan and other services the member may be receiving. |

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Medicaid agency | ☐ | Operating agency | ☐ | Case manager |
| X | Other (*specify):* | Integrated Health Home Care Coordinator for participants who are enrolled in an Integrated Health Home. The case manager maintains service plans for fee-for-service members. MCO community-based case managers maintain MCO member service plans. | | | |

## Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

| | |
|---|---|
| **Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):* | |
| Service Title: | HCBS Case Management |
| Service Definition (Scope)*:* | |
| | |
| Additional needs-based criteria for receiving the service, if applicable *(specify):* | |
| Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management under the Medicaid State plan cannot also receive case management under Section 1915(i). Participants are free to choose their provider. | |
| Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.<br>*(Choose each that applies):* | |

| | |
|---|---|
| ☐ | Categorically needy *(specify limits):* |
| | |
| ☐ | Medically needy *(specify limits):* |
| | |

**Provider Qualifications** *(For each type of provider. Copy rows as needed)*:

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| Case Management Provider | | Providers must be certified under Iowa Administrative Code 441-24, which includes meeting the following qualifications:<br>1. Has a bachelor's degree with 30 semester hours or equivalent semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services.<br>-Or-<br>2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services. | Case Management Provider |

**Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed)*:

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| Case Management Provider | Iowa Department of Human Services, Iowa Medicaid Enterprise | Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years) |

**Service Delivery Method.** *(Check each that applies)*:

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | X | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the*

*state plans to cover):*

| Service Title: | Habilitation |
|---|---|

Service Definition (Scope)*:*

Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Components of this service include the following:

1. **Home-based Habilitation** means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision. Home-based habilitation is not covered for participants residing in a residential care facility of more than 16 persons.

2. **Day Habilitation** means provision of regularly scheduled activities in a non-residential setting separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

   Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

   Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

   Day habilitation may be furnished in any of a variety of settings in the community other than the person's private residence. Day habilitation services are not limited to fixed-site facilities.

   When transportation is provided between the participants' place of residence and the Day Habilitation service site(s) as a component part of this service the cost of transportation is included in the rate paid to providers of day habilitation services.

3. **Prevocational Habilitation** are services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process.

Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan, the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.

Prevocational Habilitation services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Example include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers, generally accepted community workplace conduct and dress, ability to follow directions, ability to attend to tasks, workplace problem solving skills and strategies, general workplace safety and mobility training.

Prevocational Habilitation may be furnished in any variety of settings in the community other than the person's private residence, the provider administrative offices, or other settings that have the effect of isolating the member from the greater community.

When transportation is provided between the participants' place of residence and the Prevocational Habilitation service site(s) as a component part of this service the cost of transportation is included in the rate paid to providers of prevocational habilitation service.

Personal care and assistance may be a component of prevocational services, but may not comprise the entirety of the service.

Members who receive prevocational services may also receive educational, supported employment, and day habilitation services. A member's person centered services and supports plan may include two or more types of nonresidential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Prevocational services may be furnished to any member who requires and chooses them through a person-centered planning process.

Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly the evidence-based Individual Placement and Support (IPS) model of supported employments for individuals with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

**4. Supported Employment Habilitation**

**Supported Employment – Individual Employment Support** services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting. Supported employment individual employment supports is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment Small Group employment support.

Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the DEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of employment services.

**Supported Employment Small Group employment support (Enclave)** are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience

leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include vocational services provided in facility based work settings. Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment support services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Supported Employment Habilitation may be furnished in any of a variety of settings in the community other than the person's private residence with the exception of individual employment supports provided to an individual who is self-employed or who has an employment situation where working from the home or a home office is typical for such a position.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Participants have a need for support and assistance in accessing services.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(chose each that applies):*

☑ Categorically needy *(specify limits):*

| | |
|---|---|
| | A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).<br><br>The daily unit of services shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.<br><br>A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).<br><br>A unit of prevocational habilitation is an hour (up to 4 units per day) or a full day (4.25 to 8 hours).<br><br>A unit of supported employment habilitation for activities to obtain a job is:<br>1. One job placement for job development and employer development.<br>2. A 15-minute unit for enhanced job search.<br><br>A unit of supported employment habilitation supports to maintain employment is a 15-minute unit, maximum of 160 15 min units per week. Not to exceed $3,029.00 per month<br><br>All limits are subject to change each year. All component of habilitation being utilized must be authorized in the participant's service plan or treatment plan. The MCO community-based case manager or case manager will monitor the service plan. The Integrated Health Home Care Coordinator will monitor the treatment plan. |
| ☑ | Medically needy *(specify limits):* |

A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

A unit of prevocational habilitation is an hour (up to 4 units per day) or a full day (4.25 to 8 hours).

A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. A 15-minute unit for enhanced job search.

A unit of supported employment habilitation supports to maintain employment is a 15-minute unit, maximum of 160 units per week. $3,029.00 per month.

All limits are subject to change each year. All component of habilitation being utilized must be authorized in the participant's service plan or treatment plan. The MCO community-based case manager or case manager will monitor the service plan. The Integrated Health Home Care Coordinator will monitor the treatment plan.

**Provider Qualifications** *(For each type of provider. Copy rows as needed)*:

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| Home-based habilitation providers | | Meet any of the following:<br>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)<br>• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)<br>• Accredited by the Council on Accreditation (COA)<br>• Accredited by the Council on Quality and Leadership (CQL)<br>• Certified by the bureau of long term care of the Iowa Medicaid | |

| | | | |
|---|---|---|---|
| | | Enterprise as a provider of Supported Community Living for the HCBS ID Waiver under 441-IAC 77.37(1) through 77.37(14) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(13).<br>• Certified by the department as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12). | |
| Day habilitation providers | | Meet any of the following:<br>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)<br>• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)<br>• Accredited by the Council on Accreditation (COA)<br>• Accredited by the Council on Quality and Leadership (CQL)<br>• Accredited by the International Center for Clubhouse Development (ICCD)<br>• Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Day Habilitation for the HCBS ID Waiver under 441-IAC 77.37(13) and 77.37(27).<br>• Certified by the department as a provider of Day Treatment under 441-IAC 24.2 through 24.4(8) and 24.4(10) or Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12). | |
| Prevocational habilitation providers | | Meet any of the following:<br>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)<br>• Accredited by the Council on | |

| | | | |
|---|---|---|---|
| | | Quality and Leadership (CQL)<br>• Accredited by the International Center for Clubhouse Development (ICCD)<br>• Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Prevocational services for the HCBS ID Waiver under 441-IAC 77.37(13) and 77.37(26) or the HCBS BI Waiver under 441-IAC 77.39(22). | |
| Supported employment habilitation providers | | Meet any of the following:<br>• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)<br>• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)<br>• Accredited by the Council on Accreditation (COA)<br>• Accredited by the Council on Quality and Leadership (CQL)<br>• Accredited by the International Center for Clubhouse Development (ICCD)<br>• Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Employment for the HCBS ID Waiver under 441-IAC 77.37(1) through 77.37(13) and 77.37(16) or the HCBS BI waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(15). | |

**Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed)*:

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| Home-based habilitation providers | Iowa Department of Human Services, Iowa Medicaid Enterprise | Verified at initial certification and thereafter based on the length of certification: |

| | | |
|---|---|---|
| | MCO | • Either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers or certified under IAC 441-24<br>• Either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA<br>• 3 years when accredited by JCAHO<br>• 4 years when accredited by CQL<br><br>Verified at initial certification and thereafter based on the length of the certification. |
| Day habilitation providers | Iowa Department of Human Services, Iowa Medicaid Enterprise<br><br>MCO | Verified at initial certification and thereafter based on the length of certification:<br>• Either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS ID Waiver certified under IAC 441-24<br>• Either 1 year or 3 years when accredited by CARF or ICCD<br>• 3 years when accredited by JCAHO<br>• 4 years when accredited by CQL<br><br>Verified at initial certification and thereafter based on the length of the certification. |
| Prevocational habilitation providers | Iowa Department of Human Services, Iowa Medicaid Enterprise | Verified at initial certification and thereafter based on the length of certification: |

| | | |
|---|---|---|
| | MCO | • Either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers<br>• Either 1 year or 3 years when accredited by CARF or ICCD<br>• Either 3 years or 4 years when accredited by COA<br>• 3 years when accredited by JCAHO<br>• 4 years when accredited by CQL<br><br>Verified at initial certification and thereafter based on the length of the certification. |
| Supported employment habilitation providers | Iowa Department of Human Services, Iowa Medicaid Enterprise<br><br>MCO | Verified at initial certification and thereafter based on the length of certification:<br>• Either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers<br>• Either 1 year or 3 years when accredited by CARF or ICCD<br>• Either 3 years or 4 years when accredited by COA<br>• 3 years when accredited by JCAHO<br>• 4 years when accredited by CQL<br><br>Verified at initial certification and thereafter based on the length of the certification. |

**Service Delivery Method.** *(Check each that applies)*:

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

2. X **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

| |
|---|
| The state does not make payment for State plan HCBS furnished by relatives, legally responsible individuals, or legal guardians. |

## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

1. **Election of Participant-Direction**. (S*elect one):*

| | |
|---|---|
| X | The state does not offer opportunity for participant-direction of State plan HCBS. |
| ○ | Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services. |
| ○ | Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):* |
| | |

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

| |
|---|
| |

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

| | |
|---|---|
| ○ | Participant direction is available in all geographic areas in which State plan HCBS are available. |
| ○ | Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state* |

| | |
|---|---|
| | *affected by this option*): |
| | |

4. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

| Participant-Directed Service | Employer Authority | Budget Authority |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |

5. **Financial Management.** (*Select one):*

| | |
|---|---|
| ○ | Financial Management is not furnished. Standard Medicaid payment mechanisms are used. |
| ○ | Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan. |

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

| |
|---|
| |

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

| | |
|---|---|
| X | The state does not offer opportunity for participant-employer authority. |
| ○ | Participants may elect participant-employer Authority *(Check each that applies):* |

| | | |
|---|---|---|
| | ☐ | **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. |
| | ☐ | **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions. |

**b. Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

| | |
|---|---|
| X | The state does not offer opportunity for participants to direct a budget. |
| ○ | Participants may elect Participant–Budget Authority. |
| | **Participant-Directed Budget**. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):* |
| | |
| | **Expenditure Safeguards.** *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.* |
| | |

## Quality Improvement Strategy

*(Describe the state's quality improvement strategy in the tables below):*

| Discovery Activities | | | | | Remediation | |
|---|---|---|---|---|---|---|
| **Requirement** | **Discovery Evidence** *(Performance Measures)* | **Discovery Activity** *(Source of Data & sample size)* | **Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)* | **Frequency** | **Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)* | **Frequency** *(Analysis and Aggregation)* |
| Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. | SP-1: Number and percent of service plans reviewed which address the member's assessed health risks. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | State Medicaid Agency & Contracted Entity (Including MCOs) | Data is Collected Monthly | The MCO ensures that the Case Manager, Community-based Case Manager or Integrated Health Home Care Coordinator has addressed the member's health and safety needs in the member's service or treatment plan.<br><br>The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider, Case Manager, or Integrated Health Home and target training and technical assistance to those deficiencies. General methods for problem correction at a systemic level include informational letters, provider training, and collaboration with stakeholders and changes in policy. | Data is Aggregated and Analyzed Continuously and Ongoing |
| | SP-2: Number and percent of service plans | Member service plans are reviewed at a 95% confidence level on a | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed |

| | | | | | | |
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| | which address the member's assessed safety risks. | three-year cycle. Data is inductively analyzed and reported to the state. | | | | Quarterly |
| | SP-3: Number and percent of service plans which reflect the member's assessed personal goals. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-4: Number and percent of service plans, which include signature of member on the service plan. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-5: Number and percent of service plans which list all services received by the member. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-6: Number and percent of service plans which list all of the member's providers. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-7: Number and percent of service plans in which all funding | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |

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| | sources are listed. | is inductively analyzed and reported to the state. | | | | |
| | SP-8: Number and percent of service plans, which list the amount of services to be received by the member. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-9: Number and percent of service plans which are revised on or before member's annual due date. | Reports are pulled from ISIS and MCO data to illustrate the number of service plans that were revised prior to the due date. Data is inductively analyzed at a 100% level. | State Medicaid Agency & Contracted Entity (Including MCOs) | Data is Collected Quarterly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-10: Number and percent of service plans, which were revised when warranted by a change in the member's needs. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-11: Number and percent of member surveys reporting the receipt of all services identified in the plan. | The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-12: Number and percent of service plan | Member service plans are reviewed at a 95% confidence level on a | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed |

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| | reviews reporting the receipt of all services identified in the plan. | three-year cycle. Data is inductively analyzed and reported to the state. | | | | Quarterly |
| | SP-13: Number and percent of experience/satisfaction survey respondents who indicate that they received a choice of providers. | The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-14: Number and percent of service plans with a plan for supports available to the member in the event of an emergency. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | SP-15: Number and percent of service plans that indicate the member was provided a choice of providers for service delivery. | Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See SP-1 Above | Data is Aggregated and Analyzed Quarterly |
| Providers meet required qualifications. | QP-1: Number and percent of provider enrollment applications verified against the appropriate licensing and/or certification entity. | OnBase (workflow management) reports and MCO data are used to retrieve data on the number of enrollment applications that are verified and approved. Data is inductively | Contracted Entity (Including MCOs) | Data is Collected Continuously and Ongoing | Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by the Provider Services unit or MCO during the review that the provider is not compliant in one of the enrollment and reenrollment state or | Data is Aggregated and Analyzed Quarterly |

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| | | analyzed at a 100% level. | | | federal provider requirements, they are required to correct the deficiency prior to enrollment or reenrollment approval. Until they make these corrections, they are ineligible to provide services to members. If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders, and changes in policy. | |
| | QP-2: Number and percent of licensed/certified provider enrollments indicating that abuse and criminal background checks were completed prior to direct service delivery. | OnBase and MCO reports are used to retrieve data on the number of enrollment applications that are verified and approved. Data is inductively analyzed at a 100% level. | Contracted Entity (Including MCOs) | Data is Collected Continuously and Ongoing | See QP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | QP-3: Number and percent of currently enrolled licensed/certified providers verified against the appropriate licensing and/or certification entity. | OnBase and MCO reports are used to retrieve data associated with the number of reenrollment applications that are verified and approved. Data is inductively analyzed at a 100% | Contracted Entity (Including MCOs) | Data is Collected Continuously and Ongoing | See QP-1 Above | Data is Aggregated and Analyzed Quarterly |

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| | | level. | | | | |
| | QP-4: Number and percent of providers that meet training requirements as outlined in state regulations. | OnBase and MCO reports are used to retrieve data associated with the number reviewed providers who meet training requirements. Data is inductively analyzed of 100% sample spread over 5 years. | Contracted Entity (Including MCOs) | Data is Collected Continuously and Ongoing | See QP-1 Above | Data is Aggregated and Analyzed Quarterly |
| | QP-5: Number and percent of non-licensed/non-certified applicants who met the required provider standards. | OnBase and MCO reports are used to retrieve data associated with the number of enrollment applications with approved standards. Data is inductively analyzed at a 100% level. | Contracted Entity (Including MCOs) | Data is Collected Quarterly | See QP-1 Above | Data is Aggregated and Analyzed Quarterly |
| Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR | SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. | Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the | Contracted Entity (Including MCOs) | Data is Collected Continuously and Ongoing | Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The IME Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB | Data is Aggregated and Analyzed Quarterly |

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| 441.710(a)(1) and (2). | | state. | | | service provider(s) and the Case Manager or IHH Care Coordinator. The IME Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review. | |
| The SMA retains authority and responsibility for program operations and oversight. | AA-1: Number and percent of quarterly contract management reports, from the Medical Services Contractor and MCO, submitted within ten business days of the end of the reporting period. | Contracted Entity and MCO performance monitoring. Data is inductively analyzed at a 100% level. | Contracted Entity (Including MCOs) | Data is Collected Quarterly | Each operating agency within the Iowa Medicaid Enterprise is assigned state staff to serve as a contract manager. This position oversees the quality and timeliness of monthly scorecards and quarterly contract reports. Further, the Iowa Medicaid Enterprise holds a monthly manager meeting in which the account managers of each contracted unit presents the operational and performance issues discovered and remediated within the past month. This allows all state staff to collectively sustain transparent administrative oversight. If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the contracted unit, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation. | Data is Aggregated and Analyzed Quarterly |
| | AA-2: Number and percent of quarterly contract management reports, from the HCBS QA Contractor, submitted within ten business days of the end of the reporting period. | Contracted Entity performance monitoring. Data is inductively analyzed at a 100% level. | Contracted Entity | Data is Collected Quarterly | See AA-1 Above | Data is Aggregated and Analyzed Quarterly |

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| | AA-3: Number and percent of monthly major incident reports, from the HCBS QA Contractor and MCO, submitted within ten business days of the end of the reporting period. | Contracted Entity and MCO performance monitoring. Data is inductively analyzed at a 100% level. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See AA-1 Above | Data is Aggregated and Analyzed Quarterly |
| | AA-5: Number and percent of quarterly contract management reports, from the Provider Services Contractor, submitted within ten business days of the end of the reporting period. | Contracted Entity performance monitoring. Data is inductively analyzed at a 100% level. | Contracted Entity | Data is Collected Quarterly | See AA-1 Above | Data is Aggregated and Analyzed Quarterly |
| | AA-6: Number and amount of compensation withholdings, for the Provider Services Contractor, annually applied for inaccurate provider enrollment functions. Measured by the monetary units withheld as compensation from contract payments. | Contracted Entity performance monitoring. Data is inductively analyzed at a 100% level. | State Medicaid Agency | Data is Collected Annually | See AA-1 Above | Data is Aggregated and Analyzed Quarterly |
| | AA-7: Number and amount of compensation withholdings, for the HCBS QA contractor and MCO, annually applied for | Contracted Entity and MCO performance monitoring. Data is inductively analyzed at a 100% level. | State Medicaid Agency | Data is Collected Annually | See AA-1 Above | Data is Aggregated and Analyzed Quarterly |

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| | inappropriate quality assurance activities. Measured by the monetary units withheld as compensation from contract payments. | | | | | |
| The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers. | FA-1: Number and percent of reviewed paid claims for which the units of service lacked supporting documentation. | The Program Integrity unit requests service documentation from providers and cross-walks with claims. The Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. | Contracted Entity (Including MCOs) | Data is Collected Quarterly | When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension. The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis. | Data is Aggregated and Analyzed Quarterly |
| | FA-2: Number and percent of reviewed paid claims for which the units of service were coded as specified. | The Program Integrity Unit<br>The Program Integrity unit requests service documentation from providers and cross-walks with claims. The Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. | Contracted Entity (Including MCOs) | Data is Collected Quarterly | See FA-1 Above | Data is Aggregated and Analyzed Quarterly |
| | FA-3: Number and percent of reviewed | The Medical Services Unit reports | Contracted Entity (Including | Data is Collected | See FA-1 Above | Data is Aggregated |

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| | exception to policy (ETP) requests for which rates were paid using the methodology other than specified. | quarterly on ETP trends. This data is analyzed inductively. | MCOs) | Quarterly | | and Analyzed Quarterly |
| The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints. | HW-1: Number, percent, and frequency of major incidents, by type. | MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed at 100%. | Contracted Entity (Including MCOs) | Data is Collected Monthly, Quarterly, and Annually | The HCBS Incident Reporting Specialist analyzes data for individual and systemic issues. Individual issues require communication with the service worker, case manager, IHH coordinator or MCO community-based case manager to document all efforts to remediate risk or concern. If these efforts are not successful, the IR Specialist continues efforts to communicate with the service worker, case manager, IHH coordinator or MCO community-based case manager their supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports. The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the service worker, case manager, IHH coordinator or MCO community-based case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. General methods for problem correction at a systemic level include informational letters, provider | Data is Aggregated and Analyzed Quarterly |

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| | | | | | training, collaboration with stakeholders, and changes in policy. In addition, Contracted Entities (including MCOs) initiate a quality of care review of all known adverse incidents involving a member who is receiving services or having care managed by the contractor. When contractor staff becomes aware of an adverse incident the incident is communicated to medical directors and/or compliance staff. If deemed high-risk the compliance staff requests recourse from the service provider and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the contractor's legal department is required to review the case to determine if an incident review is required. A full audit of the incident must be completed within 15 days. The contractor must then submit the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow-up with the contractor. | |
| | HW-2: Number and percent of major incidents that were reported within required timeframes. | IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on timeliness is inductively analyzed at 100%. | Contracted Entity (Including MCOs) | Data is Collected Monthly, Quarterly, and Annually | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |
| | HW-3: Number and percent of unexplained, | IMPA reports are generated by the HCBS | Contracted | Data is Collected | See HW-1 Above | Data is |

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| | suspicious or untimely deaths compared to the total number of deaths. | Incident Reporting Specialist. This data on suspicious or untimely deaths is inductively analyzed at 100%. | Entity (Including MCOs) | Monthly, Quarterly, and Annually | | Aggregated and Analyzed Quarterly |
| | HW-4: Number and percent of service plans that indicate the members were informed of how to report suspected abuse, neglect, or exploitation. | Member service plans are reviewed at a 95% confidence level. | Contracted Entity (Including MCOs) | Data is Collected Annually (or More Often Based on Members' Needs) | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |
| | HW-5: Number and percent of member survey respondents who reported they feel safe in their living environment. | The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |
| | HW-6: Number and percent of experience/satisfaction survey respondents who reported that somewhat hit or hurt them physically. | The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |
| | HW-7: Number and percent of experience/satisfaction survey respondents who reported they do not feel safe with the people they live with. | The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed. | Contracted Entity (Including MCOs) | Data is Collected Monthly | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |
| | HW-8: The number and percentage of restrictive interventions | IMPA reports are generated by the HCBS Incident Reporting | Contracted Entity (Including MCOs) | Data is Collected Continuously | See HW-1 Above | Data is Aggregated and Analyzed |

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| | applied that were not in the member's service plan, or were not applied as indicated in the service plan. | Specialist. This data on restrictive interventions is inductively analyzed at a 95% confidence level. | | and Ongoing | | Quarterly |
| | HW-9: Number and percent of medication errors that resulted in a participant requiring medical treatment. | IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on medication errors is inductively analyzed at 100%. | Contracted Entity (Including MCOs) | Data is Collected Monthly, Quarterly, and Annually | See HW-1 Above | Data is Aggregated and Analyzed Quarterly |

| **System Improvement**: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)* | | | |
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| Methods for Analyzing Data and Prioritizing Need for System Improvement | Roles and Responsibilities | Frequency | Method for Evaluating Effectiveness of System Changes |
| The State QA/QI system, at a minimum, addresses the following items: (1) health and safety issues of members receiving HCBS services; (2) abuse/neglect/ exploitation of members; (3) member access to services; (4) plan of care discrepancies; (5) availability of services; (6) complaints of service delivery; (7) training of providers, case managers, and other stakeholders; (8) emergency procedures; (9) provider qualifications; and (10) member choice. | The IME is the single state agency that retains administrative authority of Iowa's HCBS services. Iowa remains highly committed to continually improve the quality of services for all HCBS programs. The QIS developed by Iowa stratifies all HCBS services, including the State's 1915(c) waivers and 1915(i) state plan services. Data is derived from a variety of sources including the MCOs, HCBS Provider Quality Oversight databases, site reviews, follow-up compliance reviews, compliant investigations, evaluation reports, member satisfaction surveys, member interviews, and member records. | Data is Collected Continuously and Ongoing | The IME reviews the State QIS system no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate |

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| | | | of the member and provider communities.<br><br>The IME employs a Quality Assurance Manager to oversee data compilation and remediation activities. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.<br><br>Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a |

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| | | | monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. Data from QA/QI activities is also presented to the HCBS QA/AI Committee on a quarterly basis. The QA/QI Committee reviews the data makes recommendations for changes in policy to the IME Policy staff and Bureau Chief. The Committee also uses this information to direct HCBS Provider Quality Oversight Specialists to provide training, technical assistance, or other activity. The Committee monitors training and technical assistance activities to assure consistent implementation statewide. The Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed. The Committee is made up of certain HCBS Provider Quality Oversight staff and supervisors, and IME Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvements are made.<br><br>Finally, IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa Association of Community Care Providers. Reports are also available to agencies, waiver providers, participants, families, and other interested parties upon request. |
| In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of | MCOs must comply with the standards established by the State and must provide all | Reviews are Conducted Annually | The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this |

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| services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. | information and reporting necessary for the State to carry out its obligations for the State quality strategy. IME performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports. | | is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan.<br><br>In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS. |
| All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. | MCO QM/QI programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the | Reviews are Conducted Annually | The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state an authenticated as it can be used during onsite visits and through regular reports. |

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| | MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QA/QI plan. | | |
| MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. | If not already accredited, the MCO must demonstrate it has initiated the accreditation process as of the MCO's contract effective date. The MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State. When accreditation standards conflict with the standards set forth in the MCO's contract, the contract prevails unless the accreditation standard is more stringent.<br><br>MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed. | Reviews are Conducted Every Three Years | NCQA and URAC publically report summarized plan performance, as well as accreditation type, accreditation expiration date, date of next review and accreditation status for all NCQA accredited plans in a report card available on the NCQA website. This report card provides a summary of overall plan performance on a number of standards and measures through an accreditation start rating comprised of five categories (access and service, qualified providers, staying health, getting better, living with illness). |

## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

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| ☑ | HCBS Case Management |
| | Providers of case management services shall be reimbursed at cost. Providers are reimbursed throughout each fiscal year on the basis of a projected interim payment rate for a 15-minute unit of service based on each provider's reasonable and proper costs of operation. Reasonable and proper costs of operation are identified pursuant to federally accepted reimbursement principles (OMB A-87 principles).<br><br>The methodology for determining the reasonable and proper cost for service provision assumes the following:<br>• The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.<br>• Mileage shall be reimbursed at a rate no greater than the state employee rate.<br>• Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).<br><br>Interim payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664., Financial and Statistical Report submitted by providers ninety days after each fiscal year end. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost apportionment.<br><br>MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Year 2, the State assumed that the same number of unique individuals would receive services for the year, although the payment basis will be blended between fee-for-service and managed care based on the effective date and managed care implementation date. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. |
| ☑ | HCBS Home-Based Habilitation |
| | For services provided on July 1, 2013 through December 31, 2013, home-based habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.<br><br>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee |

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| | schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date.<br><br>All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule<br><br>MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Year 2, the State assumed that the same number of unique individuals would receive services for the year, although the payment basis will be blended between fee-for-service and managed care based on the effective date and managed care implementation date. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. |

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| ☑ | HCBS Day Habilitation |
| | For services provided on July 1, 2013 through December 31, 2013, day habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.<br><br>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. Day Habilitation rates are fees schedules based on a rate that is contracted with the local county, or in the absence of a county contract rate, the provider's rate not to exceed the upper rate limit listed at 441 IAC 79.1(2).<br><br>MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Year 2, the State assumed that the same number of unique individuals would receive services for the year, although the payment basis will be blended between fee-for-service and managed care based on the effective date and managed care implementation date. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. |

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| | Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. |
| ☐ | HCBS Behavioral Habilitation |
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| ☐ | HCBS Educational Services |
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| ☑ | HCBS Prevocational Habilitation |
| | For services provided on July 1, 2013 through December 31, 2013, prevocational habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013.<br><br>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. Prevocational service rates are fees schedules based on a rate that is contracted with the local county, or in the absence of a county contract rate, the provider's rate not to exceed the upper rate limit listed at 441 IAC 79.1(2).<br><br>MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Year 2, the State assumed that the same number of unique individuals would receive services for the year, although the payment basis will be blended between fee-for-service and managed care based on the effective date and managed care implementation date. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. |
| ☑ | HCBS Supported Employment Habilitation |
| | For services provided on July 1, 2013 through December 31, 2013, supported employment habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fee schedule rate was set as of July 1, 2013 and is effective for dates of service provided on and after that date through December 31, 2013.<br><br>For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. Supported Employment rates are fees schedules based on a rate that is contracted with the local county, or in the absence of a county contract rate, the provider's rate not to exceed the upper rate limit listed at 441 IAC 79.1(2)<br><br>MCO capitation rate development methodologies are described in the §1915(b) waiver |

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| | and associated materials. To estimate the fee-for-service population in Year 2, the State assumed that the same number of unique individuals would receive services for the year, although the payment basis will be blended between fee-for-service and managed care based on the effective date and managed care implementation date. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. |