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 & Case Management.

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

   Select one:

O	**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:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the1915(a) contract has been submitted or previously approved.*
X	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* Iowa High Quality Healthcare Initiative (Approved 2/23/16, Effective 4/1/16)

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)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment*

☐	*has been submitted or previously approved:*
☐	**A program authorized under §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
	O	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.	
O	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. The Iowa Medicaid Enterprise's Medical Services Unit via contractor 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 via contractor maintains final review and approval authority.
3. 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.

4. 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.
5. 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.
6. Recruitment of providers may be done by Iowa Medicaid Enterprise policy staff or by the MCOs.
7. 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.
8. 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.
9. 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.
10. 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 IME Core Standardized Assessment Contractor, Integrated Health Home Care Coordinator, MCO community-based case manager, or Targeted Case Manager completes the interRAI Community Mental Health Assessment Tool 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. 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*):

O	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. The interRAI Community Mental Health (CMHC) is used to determine if the member meets the needs based criteria for services. The initial assessment is completed by the Core Standardized Assessment (CSA) contractor Telligen and sent to the case manager, care coordinator or community based case manager who uploads the assessment to the IME Medical Services Unit (MSU) 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. 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. 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. 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:

It is the responsibility of the case manager, health home coordinator, or community-based case manager to assure the assessment is initiated as required to complete the initial needs based eligibility determination. The initial assessment is completed by the Core Standardized Assessment (CSA) contractor Telligen and sent to the case manager, care coordinator or community based case manager who uploads the assessment to the IME MSU. The IME MSU is responsible for determining the needs based eligibility based on the completed assessment tool and supporting documentation from medical professionals.

The Continued Stay Review (CSR) is completed annually and uses the same assessment tool as is used with the initial needs based eligibility determination. It is the responsibility of the case manager, health home coordinator, or community-based case manager to assure the assessment is initiated as required to complete the CSR. For fee-for-service participants, the ISIS system sends out a milestone 60 days prior to the CSR date to remind the case manager, and health home coordinators of the upcoming annual LOC process.

MCOs are responsible for conducting needs based eligibility reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect needs based eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the needs based eligibility or functional eligibility information via fax to the IME MSU. The State retains authority for determining Medicaid categorical, financial, needs based eligibility or needs-based eligibility and enrolling participants into a Medicaid eligibility category. MCOs track and report needs based eligibility and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in needs based eligibility and DHS retains final needs based eligibility determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(i) amendment and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of needs based eligibility and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) needs based eligibility assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

MCOs are required to employ the same professionals as DHS for reevaluations. Further, MCOs are contractually required to ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to: (i) contract requirements and State

and Federal requirements specific to job functions; (ii) training on the MCOs policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Policies and Procedures Manuals must also be provided to the MCO's entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training. 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: ▪ 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	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. -OR- 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	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. --AND— 2. Three or more deficits resulting in substantial functional limitation in major life activity areas as defined in 42 CFR 45.1009(d): ▪ Self-care ▪ Understanding and use of language ▪ Mobility ▪ Self Direction ▪ Capacity for independent living	**Mental Status:** 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. B. Documented failure of current outpatient treatment including two or more of the following necessitating 24 hour professional observation supported by medical record documentation: ▪ Exacerbation of symptoms ▪ Noncompliance with medication regimen ▪ Lack of therapeutic response to medication ▪ Acute neuroleptic reaction ▪ Psychotropic or neuroleptic medication toxicity ▪ Lack of patient participation in the outpatient treatment program

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. -AND- 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	daily decision-making: ▪ Cognitive, mood and behavior patterns ▪ Physical functioning-Mobility ▪ Skin condition ▪ Pulmonary Status ▪ Continence ▪ Dressing and Personal Hygiene (ADLs) ▪ Nutrition ▪ Medications ▪ Communication ▪ Psycho-social		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 comprehensive treatment plan.

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.			

*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 unit.
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.

Iowa assures that the settings transition plan included in this state plan amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its 1915(i) State plan benefit when it submits the next amendment.

A copy of the State's STP can be found at https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans.

Iowa is taking a multifaceted approach to assessment of settings compliance. This includes a systemic review of the State's rules and policies and a high-level settings analysis. A comprehensive review of state administrative rules, Medicaid policy manuals, and other state standards such as provider agreements has been conducted. The matrix below provides a crosswalk from the federal regulations to the state administrative rules, and provides the status of actions needed for any gaps that were identified.

Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, home-based habilitation services, community inclusion is addressed in 441—78.27(7)"a"; and for day habilitation services in 441—78.27(8)"a".	Supports	None	N/A
For HCBS Habilitation Services supported employment services, opportunities to pursue competitive work in integrated settings is addressed in 441—IAC—78.27(10)"b".	Supports	None	N/A

Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, service plan requirements related to needs, choice, and desired individual outcomes are addressed in 441—IAC—78.27(4)"a".	Supports	None	N/A

Federal Requirement: Settings ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

State Rule	Determination	Action Needed	Timeline
For 1915(i) Habilitation Services, restraints and restrictions are addressed in 441—IAC—77.25(4) and 441—IAC—78.27(4)"c".	Supports	None	N/A

Federal Requirement: Settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

State Rule	Determination	Action Needed	Timeline

For 1915(i) Habilitation Services, individual preferences are addressed in 441-IAC -78.27 (4)"a" and use of settings used by the general public is addressed in 441-IAC 441-IAC 78.27(8)"b", 78.27(9)"a"(2)"b" and 441-IAC 78.27(10)"a"(3)	Supports	None	N/A
Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.			
State Rule	**Determination**	**Action Needed**	**Timeline**
For 1915(i) Habilitation Services, individual choice in services and providers is addressed in 441—IAC—78.27(4)	Supports	None	N/A
Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.			
State Rule	**Determination**	**Action Needed**	**Timeline**
Habilitation Services program, which do not have a requirement of this type.	Possible conflict	Rules will be amended to clarify.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017.
Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.			
State Rule	**Determination**	**Action Needed**	**Timeline**
No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017.
Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.			
State Rule	**Determination**	**Action Needed**	**Timeline**

No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017.
Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.			
State Rule	**Determination**	**Action Needed**	**Timeline**
No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017
Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.			
State Rule	**Determination**	**Action Needed**	**Timeline**
For any HCBS service provided in a residential care facility, 441—IAC—54.4(4) states that a facility "may" allow residents to provide their own furnishings.	Possibly Conflicts	Rule will be amended to explicitly allow residents to furnish and decorate their units.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017.
Federal Requirement: In provider-owned or controlled residential settings individuals have the freedom and support to control their schedules and activities and have access to food any time.			
State Rule	**Determination**	**Action Needed**	**Timeline**
No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017
Federal Requirement: In provider-owned or controlled residential settings individuals may have visitors of their choosing at any time.			
State Rule	**Determination**	**Action Needed**	**Timeline**

No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017.
Federal Requirement: In provider-owned or controlled residential settings the setting is physically accessible to the individual.			
State Rule	**Determination**	**Action Needed**	**Timeline**
No applicable rule found.	Silent	Rules will be amended to add this requirement.	Rulemaking process will be initiated by April 1, 2016 with projected effective date of January 1, 2017

Licensed Residential Facilities

For licensed facilities in which HCBS may be provided, the following survey and certification agency rules were reviewed. These rules are not under the purview of the Iowa Medicaid program and as such IME cannot directly make changes to these rules. The IME will consult with and make recommendations for changes to the Iowa Department of Inspections and Appeals (DIA), the entity that is responsible for survey and certification activities for residential care facilities and other licensed settings.

Survey and Certification Administrative Rules Summary of Results	
Rule	**Result**
481—IAC—57: Residential Care Facilities	Supports: rights to privacy, resident choice in service planning, choice in daily activities. Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.
481—IAC—62: Residential Care Facilities for Persons with Mental Illness	Supports: service plan based on individual needs and preferences, services in least restrictive environment. Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.
481—IAC—63: Residential Care Facilities for the	Supports: service plan based on individual needs and preferences, services in least restrictive environment.

Intellectually Disabled	Possible conflicts: discharge process may not offer protections equivalent to landlord tenant law, choice of roommate may be limited in certain situations, access to food at any time may be limited, access to visitors may be limited, daily schedules may be routinized.
481—IAC—69: Assisted Living Programs	Supports: Occupancy agreement must conform to landlord tenant law, service plan based on individual needs and preferences, managed risk policies uphold autonomy, lockable doors on each unit.
481—IAC—70: Adult Day Services	Supports: Service planning process is individualized to the assessed needs the member. Activities are planned based on the needs identified in a member's service plan and members are afforded choice in participation of program activities. Possible conflicts: ADC rules are either non-specific or silent on access to food, and use of community resources in service programming.

Systemic Assessment: Settings Analysis
As an initial step in assessing compliance, Iowa examined the settings associated with the services available in each of the state's HCBS programs in order to guide the state's approach to further assessment activities.

Rationale for determinations:

✓	Settings where these services provided fully comply with the regulation because the services by their nature are individualized, provided in the community or the member's private home, and allow full access to the broader community according to individual needs and preferences. Individuals choose which services and supports they receive and who provides them. Providers of these services will not undergo the site-specific assessment process.
?	Certain settings where these services are provided may require changes to fully comply with the regulation. Providers of these services will undergo the assessment process, and when necessary the remediation or heightened scrutiny processes.

Results are indicated in the following chart:

Services by Program	1915(i) Habilitation
Case Management	✓
Day Habilitation	?
Home-Based Habilitation	?
Prevocational Services	?
Supported Employment	✓

Regardless of classification in the above chart, any licensed facility in which an HCBS service is provided, will be evaluated using the method described in the STP to determine whether the setting should be subject to the heightened scrutiny process.

Site-Specific Assessment Process
Assessment activities are outlined as follows:

ID	Activity	Start Date	End Date
1	Issue Guidance for Providers	10/1/2014	10/14/2014
2	2014 Provider Self-Assessment	10/1/2014	6/30/2015
3	Provider Self-Assessment Qualitative Validation	5/1/2015	7/31/2015
4	Provider Stakeholder Group	9/1/2015	12/31/2015
5	Preliminary Onsite Assessment by HCBS Quality Oversight Unit	12/1/2014	6/30/2016
6	2015 HCBS Provider Self-Assessment	9/1/2015	6/30/2016
7	Onsite Assessment Training for MCO Community-Based Case Managers	10/1/2016	10/30/2016
8	Onsite Assessment of non-residential settings by HCBS Quality Oversight Unit	10/1/2016	3/31/18
9	Onsite Assessment by MCO Community-Based Case Managers	11/1/2016	9/30/17
10	Submission of the final Statewide Transition Plan	7/1/2017	6/30/18
11	2016 and Ongoing Provider Self-Assessment	10/1/2016	12/31/2018
12	Ongoing provider onsite assessments	1/1/2017	3/31/2018
13	Iowa Participant Experience Survey (IPES)	12/1/2014	12/31/2018
14	Ongoing information, updates and announcements	4/1/16	3/17/19
15	Ongoing stakeholder input from members, families, advocates, providers and other interested parties.	7/1/16	12/31/18

Site-Specific Assessment Outcomes (Remediation)

Iowa's remediation process capitalizes on existing HCBS quality assurance processes including identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements for providers to become compliant. Providers that fail to remediate noncompliant settings timely may be subject to sanctions by the department. Possible sanctions include:

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

Iowa Administrative Code 441-79.2(249A) identifies the grounds for sanctions and appeal rights of providers.

Remediation activities are outlined as follows:

ID	Activity	Start Date	End Date
1	Initial Public and Provider Education and Resource	4/1/2014	11/30/2014
2	Provider Assessment Findings	12/1/2014	3/31/2018
3	Provider Individual Remediation	12/1/2014	6/30/2018
4	Onsite Compliance Reviews	12/1/2014	6/30/2018

	5	Data Collection	12/1/2014	3/16/2019	
	6	Provider Sanctions	12/1/2014	3/16/2019	
	7	Member Transitions to Compliant Settings	12/1/2014	3/16/2019	
	8	Rules Changes	4/1/16	9/30/17	
	9	Rule Change collaboration with DIA	7/1/16	12/31/16	

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
4. A doctorate degree in psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy

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
4. A doctorate degree in psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy

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 MCO ensures that the comprehensive service plan :

a. Includes people chosen by the member.
b. Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
c. Is timely and occurs at times and locations of convenience to the member.
d. Reflects cultural considerations and uses plain language.
e. Includes strategies for solving a disagreement.
f. Offers choices to the member regarding services and supports the member receives and from whom.
g. Provides method to request updates.
h. Is conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
i. Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
j. May include whether and what services are self-directed.
k. Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
l. Includes risk factors and plans to minimize them.
m. Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.

The MCO ensures that the written comprehensive service plan documentation:

a. Reflects the member's strengths and preferences.

b. Reflects clinical and support needs.
c. Includes observable and measureable goals and desired outcomes.
d. Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
e. Identifies the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
f. Identifies for a member receiving Supported community living :
    a. The member's living environment at the time of enrollment,
    b. The number of hours per day of on-site staff supervision needed by the member, and
    c. The number of other members who will live with the member in the living unit.
g. Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of state plan HCBS, including:
    a. Name of the provider
    b. Service authorized
    c. Units of service authorized
h. Includes risk factors and measures in place to minimize risk.
i. Includes individualized backup plans and strategies when needed.
j. Identifies any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment.
k. Identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
l. Providers of applicable services shall provide for emergency backup staff.
m. Includes individuals important in supporting the member.
n. Includes the names of the individuals responsible for monitoring the plan.
o. Is written in plain language and understandable to the member.
p. Documents who is responsible for monitoring the plan.
q. Documents the informed consent of the member for any restrictions on the member's rights, including maintenance of personal funds and self -administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
r. Any rights restrictions must be implemented in accordance with 441 IAC 77.25(4).
s. Includes the signatures of all individuals and providers responsible.
t. Is distributed to the member and others involved in the plan.
u. Includes purchase and control of self-directed services.
v. Excludes unnecessary or inappropriate services and supports.
w. Describes how a participant is informed of services available under the State 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 plan 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.

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.

For habilitation participants who are enrolled in Health Link, the MCOs have established a process 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. The State reviewed the MCO service planning process during the readiness review and retains oversight of the MCO person-centered service planning process through a variety of monitoring and oversight strategies as described in the Quality Improvement Strategy Section.

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 e ach 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):	
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 or Integrated Health Home services under the Medicaid State plan cannot also receive case management under	

Section 1915(i). Members that are categorized as Medically Needy receive Targeted Case Management or 1915(i) Case Management (when they do not qualify for state plan Targeted Case Management) until the member is attributed and enrolled in an IHH. Reimbursement is not available for case management under multiple authorities. Because individuals can only be enrolled in one case management program, duplicate billing is avoided. Participants are free to choose their provider.

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.

(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: 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. -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.	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

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 services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

(1) Identifying the member's interests, preferences, skills, strengths and contributions,
(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
(3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
(4) Developing skills and competencies necessary to pursue competitive integrated employment

(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,

(6) Participating in community activities related to cultural, civic, and religious interests,

(7) Participating in adult learning opportunities,

(8) Participating in volunteer opportunities,

(9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,

(10) Assistance with behavior management and self-regulation,

(11) Use of transportation and other community resources,

(12) Assistance with developing and maintaining natural relationships in the community,

(13) Assistance with identifying and using natural supports,

(14) Assistance with accessing financial literacy and benefits education,

(15) Other activities deemed necessary to assist the member with full participation in the community,

Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

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

Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services. Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation services.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider

3) Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to:

- The ability to communicate effectively with supervisors, coworkers and customers,
- An understanding of generally accepted community workplace conduct and dress,
- The ability to follow directions,
- The ability to attend to tasks,
- Workplace problem-solving skills and strategies,
- General workplace safety and mobility training,
- The ability to navigate local transportation options,
- Financial literacy skills, and
- Skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

Career Exploration Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially-based informed choice regarding the goal of individual employment.

Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include:

- Business tours
- Attending industry education events
- Benefit information
- Financial literacy classes
- Attending career fairs

The expected outcome of Career Exploration is a documented Career Plan that will inform the member's employment service planning going forward.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member 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

Setting. Prevocational services shall take place in community-based nonresidential settings.

Concurrent Services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation). More than one service may not be billed during the same period of time (e.g., the same hour).

Prevocational Service Requirements

To participate in prevocational services:

(1) Member must be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from the service site for the member. If none of these options are available to a member, transportation between the member's place of residence and the service location may be included as a component part of prevocational services.

Personal care or personal assistance and protective oversight may be a component part of prevocational services, but may not comprise the entirety of the service

4) Supported Employment

Individual Supported Employment

Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Expected Outcome of Service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Individual supported employment services shall take place in integrated work settings.

For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

Individual employment strategies include but are not limited to:

- Customized employment,
- Individual placement and support, and
- Supported self-employment.
- Service activities are individualized and may include any combination of the following:
- Benefits education
- Career exploration (e.g., tours, informational interviews, job shadows)
- Employment assessment
- Assistive technology assessment
- Trial work experience
- Person-centered employment planning
- Development of visual or traditional résumés
- Job-seeking skills training and support
- Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis)
- Job analysis (e.g., work site assessment or job accommodations evaluation)
- Identifying and arranging transportation
- Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer)
- Reemployment services (if necessary due to job loss)
- Financial literacy and asset development
- Other employment support services deemed necessary to enable the member to obtain employment
- Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization
- Engagement of natural supports during initial period of employment
- Implementation of assistive technology solutions during initial period of employment
- Transportation of the member during service hours
- Initial on-the-job training to stabilization activity

Supported Self-Employment

Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment.

An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under Individual Supported Employment, assistance to establish self-employment may include:

Aid to the member in identifying potential business opportunities.

Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.

Identification of the long-term supports necessary for the individual to operate the business.

Long-Term Job Coaching

Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

Expected Outcome of Long-Term Job Coaching. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals.

An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Long-term job coaching services shall take place in integrated work settings.

For self-employment, the member's home can be considered an integrated work setting.

Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

Service Activities

Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

- Job analysis
- Job training and systematic instruction
- Training and support for use of assistive technology and adaptive aids
- Engagement of natural supports
- Transportation coordination
- Job retention training and support
- Benefits education and ongoing support
- Supports for career advancement
- Financial literacy and asset development
- Employer consultation and support
- Negotiation with employer on behalf of the member (e.g., accommodations, employment conditions, access to natural supports, and wage and benefits)
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting
- Transportation of the member during service hours
- Career exploration services leading to increased hours or career advancement

Self-Employment Long-Term Job Coaching

Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment.

In addition to the activities listed under subparagraph 78.27(10)"b"(4), assistance to maintain self-employment may include:

- Ongoing identification of the supports necessary for the individual to operate the business;
- Ongoing assistance, counseling and guidance to maintain and grow the business; and

- Ongoing benefits education and support.

Small Group Employment (2 to 8 Individuals)

Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-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 supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include, but are not limited to:

- Mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings;
- Small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

Expected Outcome of Service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment.

Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

Service Activities. Small-group supported employment services may include any combination of the following activities:

- Employment assessment
- Person-centered employment planning
- Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave)
- Job analysis
- On-the-job training and systematic instruction
- Job coaching
- Transportation planning and training
- Benefits education
- Career exploration services leading to career advancement outcomes
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting
- Transportation of the member during service hours

Service Requirements for All Supported Employment Services

Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services. Transportation of the member during service hours may be included as a component of employment services.

Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation). More than one service may not be billed during the same period of time (e.g., the same hour).

Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

Compensation. Members receiving these services are 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.

For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

Individuals receiving supported employment must have documented in the service plan a goal to achieve or to sustain individual employment.

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

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 day. The member is assigned a Home Based Habilitation Tier based on the hours of supervision and support needed based on the member's Comprehensive Functional Assessment

Intensive III 17- 24 hours per day

Intensive II 13 to 16.75 hours per day

Intensive I 9 to 12.75 hours per day

Medium Need 4.25 to 8.75 hours per day as needed

Recovery Transitional 2.25 to 4 hours per day as needed

High Recovery .25 to 2 hours per day as needed

The current Fee schedule for Home Based Habilitation may be located online at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Day Habilitation is reimbursed at 15 min unit of service up to 16 units per day, or Daily (4.25 to 8 hours) The rates for Day habilitation are located at 441 IAC 79.1(2) https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf

Prevocational services are reimbursed as an hourly unit of service. Career exploration is an hourly unit of service.

The current HCBS Prevocational and Supported Employment fee schedule may be located at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Prevocational Service Limitations

There is a time limitation for members starting prevocational services. For members starting prevocational services after May 1, 2017, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

- The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or
- The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or
- The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or
- The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or
- The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
- The member is participating in career exploration activities.

Exclusions

- Prevocational services payment shall not be made for the following:
- Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- Compensation to members for participating in prevocational services.
- Support for members volunteering in for-profit organizations and businesses

☑ Medically needy *(specify limits)*:

A unit of home-based habilitation is a day. The member is assigned a Home Based Habilitation Tier based on the hours of supervision and support needed based on the member's Comprehensive Functional Assessment

Intensive III 17- 24 hours per day

Intensive II 13 to 16.75 hours per day

Intensive I 9 to 12.75 hours per day

Medium Need 4.25 to 8.75 hours per day as needed

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- The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or
- The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or
- The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or
- The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
- The member is participating in career exploration activities.

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- Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- Compensation to members for participating in prevocational services.
- Support for members volunteering in for-profit organizations and businesses.

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: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • 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). • 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: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD) • 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).	Direct support staff shall meet the following minimum qualifications (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older. (2) A person providing direct support shall not be an immediate family member of the member. (3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 441—paragraph 78.27(8)"a," as offered through DirectCourse or Relias or other nationally recognized Training curriculum. (4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 441—paragraph

			78.27(8)"a," as offered through DirectCourse or Relias or other nationally recognized training curriculum.
Prevocational habilitation providers		Meet any of the following: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD) • 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: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD) • 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 MCO	Verified at initial certification and thereafter based on the length of certification: • 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 • Either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA • 3 years when accredited by JCAHO • 4 years when accredited by CQL Verified at initial certification and thereafter based on the length of the certification.
Day habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise MCO	Verified at initial certification and thereafter based on the length of certification: • 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

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

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

1. 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.** (*Select one):*

X	The state does not offer opportunity for participant-direction of State plan HCBS.
O	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.
O	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):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	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):*

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	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.	
O	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.
O	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.*

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: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members. The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in	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. The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members. The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly

		nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.				
	SP-2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
	SP-3 The IME will measure the number and percent of service plans which were	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	revised when warranted by a change in the member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans	and reported to the state. See SP-1 Above				
	SP-4: The IME will measure the # and percent of members' service plans that identify all the following elements; amount, duration, and funding sources of all services and all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
	SP-5: The IME will measure the number and percentage of members from the HCBS IPES who	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	responded that they had a choice of services Numerator = # of IPES respondents who stated that they were a part of planning their services; Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.	state. See SP-1 Above				
	SP-6: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers. Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed..	Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state. See SP-1 Above	State Medicaid Agency & Contracted Entity (Including MCOs	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
Providers meet required qualifications.	QP-1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified	Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by	Contracted Entity (Including MCOs)	Data is Collected Monthly	Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by Provider Services	Data is Aggregated and Analyzed Quarterly

	against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.	the IME Provider services. The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services. The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct			Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider makes these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO. 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 trainings, collaboration with stakeholders and required changes in individual provider policy.	

		noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists. .Data is inductively analyzed at a 100% level.				
	QP-2: The IME will measure the total number and percent of providers, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review	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. The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	See QP-1 Above	Data is Aggregated and Analyzed Quarterly

		The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered 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 if noncompliance persists.				
Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting	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 state.	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 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	Data is Aggregated and Analyzed Quarterly

	requirements Denominator: The total number of service plans reviewed.				Coordinator within 2 business days of completing the review.	
	SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements. Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements Denominator: The total number of service plans reviewed.	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 state.	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 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.	Data is Aggregated and Analyzed Quarterly
The SMA retains authority and responsibility for program operations and oversight.	AA-1: The IME shall measure the number and percent of required MCO HCBS Performance Measure Quarterly reports that are submitted timely. Numerator: # of MCO HCBS Performance Measure Quarterly Reports submitted timely	Contracted Entity and MCO performance monitoring. Data is inductively analyzed at a 100% level. Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are	State Medicaid Agency and Contracted Entity (Including MCOs	Data is reported Monthly	Each MCO contract manager is responsible for ensuring that the MCO submits reports timely. If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation. General methods for problem correction	Data is Aggregated and Analyzed Quarterly

	Denominator: # of MCO HCBS Performance Measure Quarterly reports due in a calendar quarter.	assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.			include revisions to state contract terms based on lessons learned.	
	AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter	Contracted Entity performance monitoring. Data is inductively analyzed at a 100% level. See AA-1 Above	State Medicaid Agency and Contracted Entity (Including MCOs	Data is Collected Monthly	See AA-1 Above	Data is Aggregated and Analyzed Quarterly

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: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims	The Program Integrity (PI) unit requests service documentation from providers and cross-walks with claims. The Program Integrity Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. 100% of these providers are reviewed quarterly.	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 quarterly basis. If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.	Data is Aggregated and Analyzed Quarterly
	FA-2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator = # of	100% of MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care. Data sources includes; Claims Data, adjudicated claims summary, claims aging summary, and claims lag report	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	Managed Care provider claims.					
	FA-3: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.	See FA-2	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-2 Above	Data is Aggregated and Analyzed Quarterly
	FA-4: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.	See FA-2	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-2	Data is Aggregated and Analyzed Quarterly

The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	HW-1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated. Numerator = # of critical incidents that received follow-up as required; Denominator = # of critical incidents requiring follow-up escalation	100% of Incident Reports are reviewed The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.	Contracted Entity (Including MCOs)	Data is Collected Monthly,	The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If a these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's 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 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. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.	Data is Aggregated and Analyzed Quarterly

		The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.				

	HW-2 The IME will measure Critical Incident Reports (CRIS) that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIRs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death	See HW-1 Above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Quarterly
	HW-3: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days; Denominator = # of	See HW-1 above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Monthly, Quarterly and Annually

	critical incidents that resulted in a targeted review					
	HW-4: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed that identified having policies for restrictive measures.	Provider's policies and procedures. 100% of all certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.	Contracted Entity (Including MCOs)	Data is Collected Monthly	The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review.. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly
	HW-5 The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan;	Provider's policies and procedures. 100% of all certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.	Contracted Entity (Including MCOs)	Data is Collected Monthly	The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review.. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly

	Denominator = # of provider Quality Assurance Reviews completed.					
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	LC-1: Number and percent of new enrollees who had an evaluation indicating the individual 1915(i) eligible prior to receipt of services. Numerator: # of needs based eligibility reviews completed prior to the receipt of services Denominator: # of reviewed needs based eligibility reviews	The data informing this performance measure is pulled from ISIS and MCO data The Medical Services Unit performs internal quality reviews on a representative sample of the 1915(i) eligibility determinations that have been made with a 95% confidence level.	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	The state's Medical Services Unit performs internal quality reviews of initial and annual 1915(i) eligibility determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new 1915(i) eligibility determination through communication with the member and care coordinator. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	LC-2: IME will measure the number and percent of needs based eligibility decisions. Numerator: # of completed needs based eligibility reviews Denominator: # of referrals for needs based eligibility review	The data informing this performance measure is pulled from ISIS Reports are pulled and data is inductively analyzed at a 100% level.	State Medicaid Agency & Contracted Entity	Data is collected monthly	See LC-1 above	Data is Aggregated and Analyzed Quarterly

The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	LC-3: The IME shall determine the number and percent of initial needs based eligibility decisions that were accurately determined by applying the approved needs based eligibility criterion using standard operating procedures. Numerator: # of needs based eligibility decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed needs based eligibility determinations.	The Medical Services Unit performs internal quality reviews on a representative sample of the 1915(i) eligibility determinations that have been made with a 95% confidence level. Data is reported on a quarterly basis and inductively analyzed. Data for completed needs based eligibility determinations is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards. Monthly a random sample of needs based eligibility decisions are selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated needs based eligibility criteria	State Medicaid Agency & Contracted Entity	Data is collected Monthly	The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff	Data is Aggregated and Analyzed Quarterly

System Improvement:

(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

Methods for Analyzing Data and	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System

Prioritizing Need for System Improvement			Changes
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. Based on contract oversight and performance measure implementation, the	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 than annually due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

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 monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.			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.

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. The QM/QI program 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 E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.			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 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.

Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage. The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement. A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.			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. 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 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.	MCOs must comply with the standards established by the State and must provide all 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.	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 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. 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	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.

	requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the 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. 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).

STATE PLAN UNDER TITLE XIX 0F THE SOCIAL SECURITY ACT

State/Territory: IOWA

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

The following methods help assure quality of care and services under the Medical Assistance program.

1. A Medical Assistance Advisory Council assists the Department in planning the scope and content of medical services provided under the program.

2. The services of professional technical advisory committees are used for consultation on all services provided under the program.

3. Procedures exist to assure that workers in local Human Services offices are able to assist people in securing necessary medical services.

4. Procedures are in effect to pay for necessary transportation of recipients to and from providers of medical and health services.

5. The State has in effect a contract with the Iowa State Department of Inspections and Appeals to survey intermediate care facilities, intermediate care facilities for persons with intellectual disabilities and skilled nursing facilities and to certify whether they meet the conditions to participate as providers of service under the Medical Assistance program.

6. The Department has in effect a Utilization Review Plan for evaluation and surveillance of the quality and quantity of all medical and health services provided under the program.

7. Physician certification, recertification and quality of care issues for the long term care population are the responsibility of the Iowa Medicaid Enterprise's Medical Services Unit, which is the Professional Standards Review Organization in Iowa.