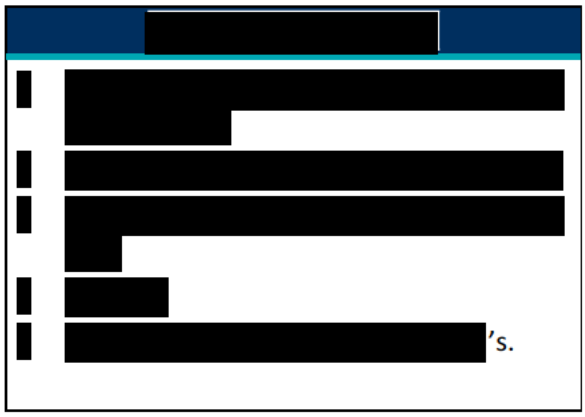
4.3 MEDICAL AND LTSS OPERATIONS (1.3.1.3)

We increase the efficiency of this project by consolidating relevant functions across medical/LTSS and HCBS scopes of work, streamlining workflow, and improving quality by implementing our approach to local contract management that we use successfully in 20 relevant contracts.



4.3.1 MEDICAL SUPPORT (A.)

A. Medical Support

1. Claims Pre-pay Reviews.

The Contractor shall review FFS claims assigned by the Agency and make decisions on individual service claims that reflect current Iowa Medicaid policy. This includes but is not limited to:

a. Manually review claims that have been suspended within the MMIS for review to determine medical necessity or appropriateness and take appropriate action to adjudicate the claims;

b. Approve payment for all reasonable and necessary medical services and supplies;

c. Manually price claims when no current fee or payment exists for the service; and

d. Update IME data systems to reflect review outcomes.

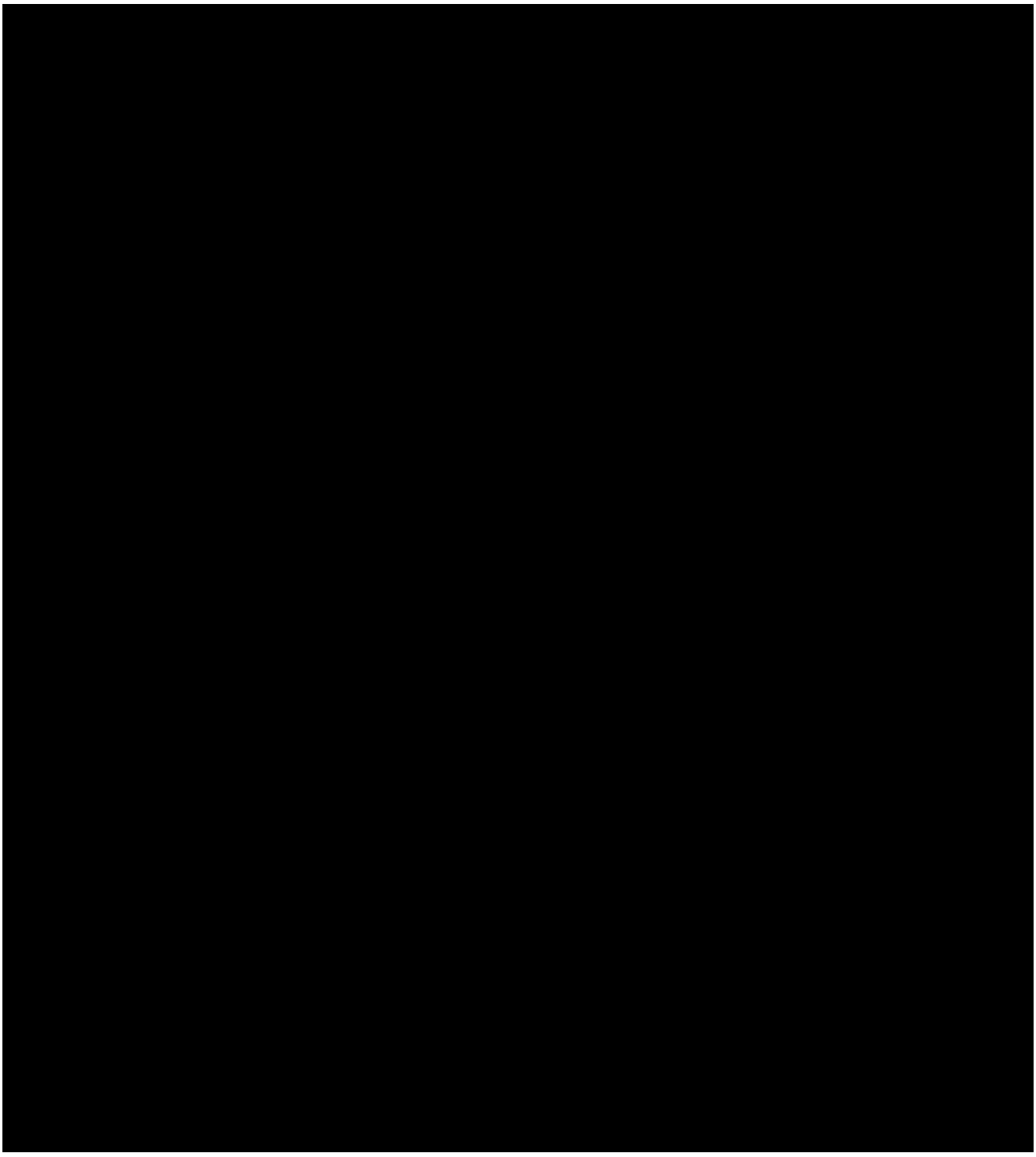


Figure 4. Claims Pre-Pay Review Process.

Our process follows national standards to ensure transition without increasing Iowa provider administrative burden or affecting Medicaid member access to services.

[redacted]

4.3.1.1 PROVIDER CLAIMS INQUIRIES.

Upon receipt of provider FFS claims inquiries, the Contractor shall

a. *Review claims information and documentation, requesting additional information if needed;*
b. *Determine whether the service is payable;*
c. *Notify the provider of the outcome of the review; and*
d. *If the service is payable, the Contractor shall update the appropriate IME data systems.*

[redacted]

[redacted]

4.3.1.2 EXCEPTIONS TO POLICY (ETP).

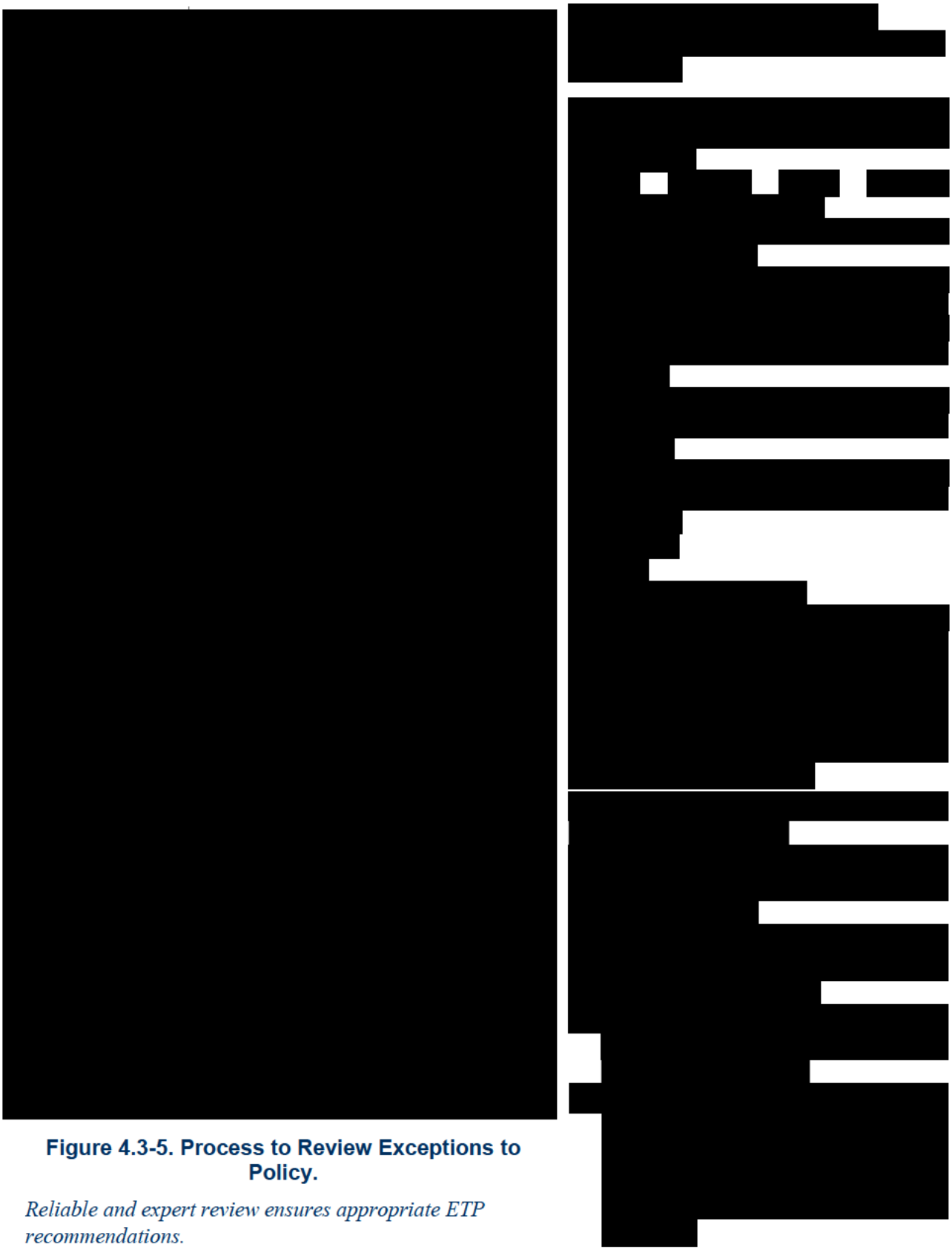


Figure 4.3-5. Process to Review Exceptions to Policy.

Reliable and expert review ensures appropriate ETP recommendations.

[redacted]

4.3.1.3 PROCEDURE AND DIAGNOSIS CODES.

The Contractor shall provide professional and technical support to the Agency related to procedure and diagnosis codes. This includes but is not limited to:

a. *Annually review ICD-10 diagnosis and surgical code and HCPCS updates;*
b. *Retrieve and review quarterly Medicaid National Correct Coding (NCCI) files and maintain accurate tracking of changes to NCCI guidelines;*
c. *Determine MMIS and policy impacts;*
d. *Update IME systems, as appropriate;*
e. *Answer MCO questions and review MCO documents related to billings, claims, and codes, as requested by the Agency; and*
f. *Participate as subject matter expert in meetings related to code updates and issues, as requested.*

[redacted]

[redacted]

4.3.1.4 CLINICAL ADVISORY COMMITTEES (CAC).

4.3.1.4.1 Medical Assistance CAC (a.)

The Medical Assistance CAC provides a process for physician/provider intervention to promote quality care, member safety, cost-effectiveness and positive physician/provider relations through discussion about Medicaid benefits and healthcare services.

In order to meet this requirement, the Contractor shall:

i. *Provide medical support, coordination and facilitation for the Medical Assistance CAC. The committee members will represent all medical services providers. The committee will meet at a minimum quarterly and consist of seven to nine medical services providers. The Contractor's MMD will chair the Medical Assistance CAC. Payment for pass-through costs shall be made as expenses are incurred as requested by the Agency, which include but are not limited to quarterly meeting costs and ad hoc committee meetings for clinical advisory committee member attendance.*

ii. *Submit a report summarizing activities of the Medical Assistance CAC to the Agency on an annual basis, within 90 days of the end of each State fiscal year.*

[redacted]

2)
3)

[redacted]

[redacted]

4) [redacted]
5) [redacted]
   - [redacted]
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6) [redacted]
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7) [redacted]
8) [redacted]
9) [redacted]
10) [redacted]
11) [redacted]

[redacted]

[redacted]

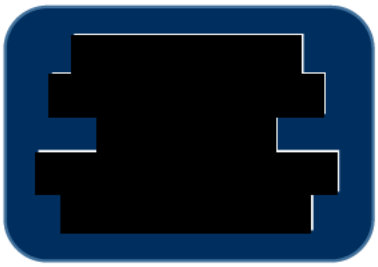
4.3.1.4.2 hawk-i CAC (b.)

Iowa Code § 514I.5(7)(i) requires the hawk-i Board to "Establish and consult with a clinical advisory committee to make recommendations to the Board regarding the clinical aspects of the hawk-i program." This committee is made up of a variety of health care professionals.

In order to meet this requirement, the Contractor's MMD shall chair the hawk-i CAC and the Contractor shall:

i. *Maintain a schedule of meetings. This includes identifying a location for the meeting and/or arranging for a conference call. Meetings shall be scheduled at least on a quarterly basis;*
ii. *Plan the agenda for the meetings;*
iii. *Record minutes of the meetings;*
iv. *Recruit committee members as needed; and*
v. *Be available to present recommendations from the committee to the hawk-i Board.*

[redacted]



[redacted]

1) [redacted]

2) [redacted]

[redacted]

4.3.1.5 MINIMUM DATA SET SUPPORT AND NURSING FACILITY CASE MIX INDEX.

a. The Contractor shall provide support and technical assistance to the Agency related to any CMS updates to the Minimum Data Set (MDS) and Resource Utilization Group (RUG) scores, including participating in CMS calls on MDS and RUG development.

b. The Contractor shall develop and maintain RUG-based methodologies, subject to Agency approval.

c. The Contractor shall extract and maintain data from the national MDS database at CMS, to include maintaining appropriate data use agreements with CMS.

d. The Contractor shall calculate a nursing facility case mix index (CMI) and resident roster on a quarterly basis, ensuring roster rules are applied consistently from quarter to quarter.

e. The Contractor shall submit the CMI and resident roster to the IME Provider Cost Audit and Rate Setting (PCA) unit for quality assurance review, and incorporate any feedback prior to submitting the resident rosters to Iowa nursing facilities.

f. The Contractor shall communicate as necessary with nursing facility staff, to include providing help desk support services to Iowa nursing facilities, related to case mix index and RUG scores developed by the Contractor.

[redacted]

Table 4.3-21. Extract of CMI Listing from IME Website.[2]

This listing identifies the multiplier for each facility based on Medicaid residents and the facility overall.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Table 4.3-22. Case Mix Index Quarterly Process

We integrate corporate and local resources for expert CMI reports and Customer Service Support

[redacted]

[redacted]

4.3.1.6 MDS SECTION "Q" INTAKE CALLS.

a. *The Contractor shall receive calls from nursing facilities reporting a resident (regardless of pay source) who identifies he or she wants to talk with someone about the possibility of returning to the community.*
b. *Following the intake calls, Contractor shall refer residents to a Local Contact Agency (designated by the IME) for options counseling and possible transition planning.*

[redacted]

4.3.1.7 PAYMENT ERROR RATE MEASUREMENT (PERM).

The Contractor shall provide support to the Agency during the CMS PERM project on a tri-annual basis, as requested. This includes but is not limited to:

a. *Monitor the PERM website as requested for new claims to be added to the list of reviews.*
b. *Providing timely medical review on all cases that were identified by the auditors and assigned to the Contractor, to include:*
    i. *Research claims information on MMIS; and*
    ii. *Medical record review including coding verification, billing and unit validation, appropriate setting of services, medical necessity of procedures and hospital stays.*
c. *Provide findings from each of the medical reviews along with detailed explanation of agreement or disagreement with the PERM auditor's findings to the Agency.*
d. *Explain in detail any disputes with CMS findings to the Agency liaison with supporting rationale from the Iowa Administrative Code (IAC) and provider manuals.*

[redacted]

[redacted]

1) [redacted]

2) [redacted]

[redacted]

4.3.1.8 THE CONTRACTOR SHALL ENSURE THAT IOWA MEDICAID POLICIES ALIGN WITH CURRENT AND/OR CHANGING MEDICAL PRACTICES.

This includes but is not limited to:

a. *Advising the Agency on changes to evidence-based best practices, national and State trends, and federal policy changes;*
b. *Consulting the Agency on requested changes to Medicaid services, whether from the Agency, providers or other stakeholders. This responsibility includes drafting proposed policy clarifications or new policy regarding services covered under the Medicaid program; and*
c. *Providing the Agency with appropriate medical and professional expertise to evaluate any requests for new or unusual services or treatment modalities and their impact on current coverage policy.*

[redacted]

[redacted]

Table 4.3-23. Consulting Cycle for IME Support

3)

Our collocated staffing model provides access, expert consulting.

[redacted]

4.3.1.9 THE CONTRACTOR SHALL PROVIDE PROFESSIONAL SUPPORT TO MEDICAID PROVIDERS REGARDING POLICY, PRIOR AUTHORIZATION OR BILLING REQUIREMENTS. THIS SUPPORT MAY BE IN THE FORM OF ORAL INSTRUCTION OR WRITTEN COMMUNICATION AND MUST BE DOCUMENTED IN AGENCY DATA SYSTEMS.

[redacted]

4.3.1.10 THE CONTRACTOR SHALL PROVIDE PROFESSIONAL AND TECHNICAL SUPPORT TO THE AGENCY IN RESPONDING TO PROGRAM REVIEWS AND AUDITS.

[redacted]

4.3.1.11 CONTRACTOR STAFF AND/OR CONSULTANTS SHALL ATTEND MEETINGS WITH PROVIDERS, MCOS, OR OTHER STAKEHOLDER GROUPS IN SUPPORT OF THE MEDICAID PROGRAM, AS REQUESTED BY THE AGENCY.

[redacted]

4.3.1.12 THE CONTRACTOR SHALL CERTIFY NEW OUTPATIENT HOSPITAL PROGRAMS FOR APPROPRIATENESS OF MEDICAID COVERAGE AND MAKE RECOMMENDATIONS TO THE AGENCY REGARDING APPROPRIATENESS OF NEW AND/OR EXISTING PROGRAMS, AND DETERMINE CRITERIA TO BE USED REGARDING COVERAGE FOR NEW AND/OR EXISTING PROGRAMS.

[redacted]

[redacted]

1) [redacted]
2) [redacted]
3) [redacted]
4) [redacted]
5) [redacted]

[redacted]

4.3.1.13 THE CONTRACTOR SHALL PREPARE, AND SUBMIT TO THE AGENCY FOR APPROVAL, THE CMS 64.96 QUARTERLY REPORT OF ABORTIONS, HYSTERECTOMIES, AND STERILIZATION, INCLUDING SUPPLEMENTAL WORKSHEETS RELATING TO ABORTIONS AND QUALIFICATIONS FOR FEDERAL FUNDING.

[redacted]

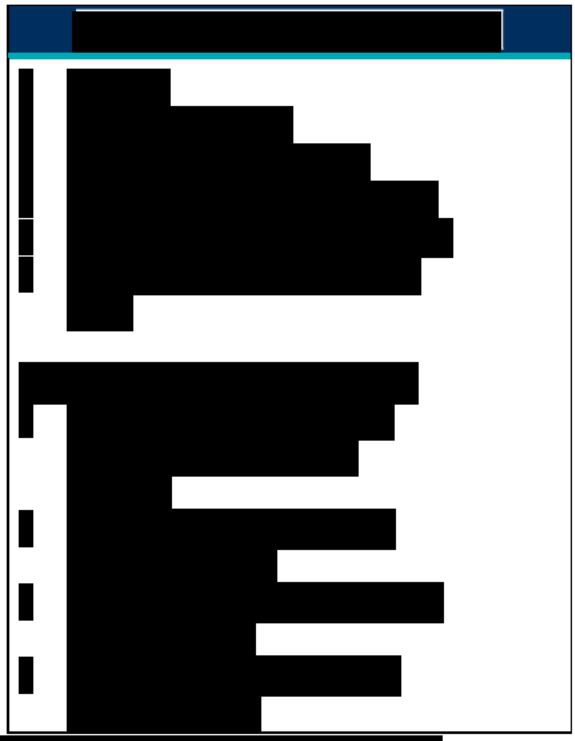
4.3.1.14 THE CONTRACTOR SHALL ASSIST THE AGENCY IN ITS EFFORTS TO SECURE GRANTS AS REQUESTED, AND PERFORM FUNCTIONS THAT ARE WITHIN THE SOW OF THIS CONTRACT THAT FALL UNDER THE GRANT.

[redacted]

4.3.2 UTILIZATION MANAGEMENT (B.)

B. Utilization Management

[redacted]



[redacted]

4.3.2.1 PRIOR AUTHORIZATIONS (PA). THIS SECTION APPLIES ONLY TO THE FFS POPULATION. (1.)

Routine PAs. (a.)

The Contractor shall process PA requests for routine services to include but not limited to:

- *i. Audiology;*
- *ii. Certain dental services, including orthodontia;*
- *iii. Certain HCBS services, including CCO;*
- *iv. Certain medical services;*
- *v. Durable medical equipment (DME);*
- *vi. Enteral;*
- *vii. Home health;*
- *viii. Psychological services;*
- *ix. Surgical, including physician administered drugs and genetic testing; and*
- *x. Organ transplant services/related; and*
- *xi. Vision.*

[redacted]

[redacted]

[redacted]

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[redacted]

Table 4.3-24. Prior Authorization Process for Routine PAs.

[redacted]

[redacted]

The Contractor shall process PA requests for the following special types of PAs:

i. Swing bed admissions and continued stays. Contractor duties include but are not limited to:

a) Determination of nursing facility or skilled nursing facility Level of Care;

b) Determination of appropriate number of days for authorization based on medical needs of the member;

c) Verification of swing-bed hospital provider efforts to locate appropriate alternative care within a 30-mile radius;

d) Necessary monitoring of swing bed providers to ensure active discharge planning is taking place; and

e) Special consideration for Iowa Wellness Plan Members, as they have different skilled nursing care benefits.

[redacted]

[redacted]

[redacted]

ii. *Behavioral health services. The Contractor shall review criteria approved by the Agency to determine medical necessity and appropriateness for and duration of hospital or other facility stays (if applicable) for persons to receive services addressing behavioral health concerns. These services include but are not limited to:*
   a) *Inpatient psychiatric hospitalization;*
   b) *Residential behavioral health treatment; and*
   c) *Psychiatric Medical Institute for Children (PMIC).*

[redacted]

1) [redacted]
2) [redacted]
3) [redacted]
4) [redacted]

iii. *Community-based neurobehavioral rehabilitation services. The Contractor shall follow criteria set forth in Iowa Admin. Code r. 441- 78.56 to determine medical necessity for initial and subsequent community-based neurobehavioral rehabilitation services. This includes but is not limited to:*

a) *Review the provider's treatment plan and supporting documentation, and approve if the following conditions are met:*

1) *The plan conforms to the medical necessity requirements;*
2) *The plan is consistent with the written diagnosis and treatment recommendations;*
3) *The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;*
4) *The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and*
5) *The plan does not exceed 180 days in duration.*

[redacted]

1) [redacted]
2) [redacted]
3) [redacted]
4) [redacted]

iv. *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Contractor shall review criteria approved by the Agency to determine medical necessity for EPSDT private duty nursing and personal care services.*

[redacted]

In addition to processing PAs, the Contractor shall conduct care promotion activities to include but not limited to:

i. *Collaborate with an interdisciplinary team, as requested, for care conferences when a decrease in the approved number of hours occurs. The interdisciplinary team reviews the options available to assist the family in maintaining their special needs member in the home.*

ii. *Provide a monthly electronic PA summary, including PAs on file for the next 6 months of authorized services, to the University of Iowa Child Health Specialty Clinic (CHSC) for their clients.*

[redacted]

v. *Facility short-stays. Contractor duties include but are not limited to:*

a) *Conduct reviews to identify short-stay approvals for members seeking admission to a Nursing Facility (NF), Skilled Nursing Facility (SNF), ICF/ID, Nursing Facility for the Mentally Ill (NF/MI), Inpatient Psychiatric Hospital, or PMIC when the prior living arrangement was a community setting.*

b) *Conduct reviews for continued stay to ensure that facility placement is for the shortest duration possible, allowing members who choose to return to the community to do so at the earliest possible opportunity.*

[redacted]

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vi. *High-tech imaging (such as MRI, MRA, CT, and PET) for radiology services, except in hospital and emergency room settings. The Contractor shall perform the medical review process for high-tech imaging that target*

variation in practice, promote cost-effective clinical decision making and increase the safety of Iowa Medicaid members.

[redacted]

1) [redacted]
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3) [redacted]
4) [redacted]

[redacted]

[redacted]

1) [redacted]
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7) [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

For any PA requests for which a decision has not been reached within 60 days of request, the Contractor shall: (e.)

- *i. Automatically approve the PA request, per Iowa Admin. Code r. 441-79.8(7)"b"; and*
- *ii. Report immediately to the Agency in writing the reason for inaction.*

[redacted]

The Contractor may approve, but cannot deny, a PA request without first referring it to a peer consultant. (f.)

[redacted]

When a PA request is denied or modified, the Contractor shall send a copy of the Request for Prior Authorization form(s) to the provider and produce and send notice of decision (NOD) to the Member and provider, on Agency-approved forms, to include but not limited to the following information: (g.)

- *i. The reason and the circumstances for the adverse action;*
- *ii. The appropriate section of the Iowa Administrative Code;*
- *iii. Information as to the specific reason for the denial that Members would understand as the basis for denial; and*
- *iv. Member appeal rights.*

When a PA request is approved, the Contractor shall send a copy of the Request for Prior Authorization form(s) to the provider with the PA decision. (h.)

[redacted]

The Contractor shall maintain PA files, to include but not limited to: (i.)

- *i. Maintain detailed audit trail reports of all changes to PA records, indicating date of last change, ID of the person making the change, and information changed for each PA record;*

ii. *Maintain PA requests and supporting documentation in the Agency workflow management system. Hardcopy requests and documentation will be imaged by the Agency-approved system contractor and be made available to the Contractor electronically; and*
iii. *Update Agency data systems with outcomes of PA decisions.*

[redacted]

The Contractor shall track, trend and analyze services requiring prior authorization and report recommendations for policy changes to the Agency as requested. (j.)
The Contractor shall submit a report of HCBS PA activities that occurred the previous month, with fiscal year-to-date totals, analysis of trends, and recommendations for improvements (including internal quality improvements) to the Agency on a monthly basis. (k.)

[redacted]

Table 4.3-25. Relevant Examples of On Demand Services and Benefits.

With capabilities and expertise in diverse medical, behavioral health, and IDD fields, we can develop and deploy innovative solutions to address client needs.

[redacted]

[redacted]

4.3.2.2 LEVEL OF CARE AND NEEDS BASED ELIGIBILITY ASSESSMENT REVIEWS FOR LTSS. (2.)

a. *The Contractor shall perform the following types of Level of Care (LOC) and needs based eligibility assessment (NBA) reviews for the LTSS programs and populations identified:*

   i. *Initial LOC Review, for all applicants or Members (FFS and MCO) upon admission or when accessing HCBS waiver program and facility (NF, SNF, ICF/ID, PMIC, and PACE) services for the first time;*
   ii. *Continued Stay Review (LOC-CSR), for HCBS waiver program and facility services, annually or when there is a significant change in the Member's needs for the following populations:*
      a) *All FFS Members; and*
      b) *Any MCO Member where the MCO determines the LOC has changed.*
   iii. *Initial NBA Review for all applicants or Members (FFS and MCO) requesting Medicaid funding for Habilitation services for the first time;*
   iv. *Continued Stay Review (NBA-CSR) for Habilitation services, annually or when there is a significant change in the Member's needs for the following populations:*
      a) *All FFS Members; and*
      b) *Any MCO Member where the MCO determines the NBA has changed.*

b. *The Contractor shall begin LOC and NBA reviews once request is received via ISIS workflow milestone, certification form, or core standardized assessment submittal.*

c. *The Contractor shall accept documentation for LOC and NBA review from the Member's physician, provider, case manager, MCO, and/or core standardized assessment (CSA) vendor. The Contractor shall request additional information, as necessary.*

d. *The Contractor shall ensure LOC and NBA reviews are based on an objective and accurate evaluation of the individuals' needs. Based on these reviews, the Contractor shall:*

   i. *Determine whether LOC and NBA criteria are met in accordance with all State and federal requirements based on information provided;*
   ii. *Approve or deny LOC or NBA requests, in accordance with criteria and within timeframes established by the Agency;*
   iii. *If services are approved, review service plan. If changes to the service plan are necessary, notify the case manager, as required;*
   iv. *Document LOC and NBA decisions within Agency data systems; and*
   v. *Produce and send notice of decision (NOD) to the Member, physician, provider, case manager, and/or facility, per Agency requirements.*

e. *The Contractor shall submit a quarterly report to the Agency on applicants and Members approved and denied for LTSS based on LOC and NBA determinations, using Agency-approved criteria.*

[redacted]

[redacted]

Table 4.3-26. Long-term Care/Needs Based Assessment Level of Care Process

Our effective process incorporates standard materials with expert reviews for reliable Level of Care determinations.

1) [redacted]
2) [redacted]
3) [redacted]

[redacted]

4) [redacted]

5) [redacted]

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7) [redacted]

8) [redacted]

9) [redacted]

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[redacted]

11) [redacted]

[redacted]

4.3.2.3 TIERED RATES. (3.)

The Contractor shall assist the Agency in determining payment tiers for supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the Intellectual Disabilities (ID) waiver. Duties include but are not limited to:

a. Determine acuity tiers based on the results of the SIS assessment tool;

b. Assign acuity tiers based on mathematically valid processes;

c. *Assign tiers to all new applicants or Members (FFS and MCO) requesting Medicaid funding for ID waiver services for the first time; and*
d. *Assign tiers annually or when there is a significant change in the Member's needs for the following populations:*
   i. *All FFS Members; and*
   ii. *Any MCO Member where the MCO determines the Level of Care has changed.*

[redacted]

[redacted]

Table 4.3-27. Rate Tiers for IDD Waiver.

Supports Intensity Scale Scores determine tiers for selected day services.

[redacted]

[redacted]

1) [redacted]

2) [redacted]

3) [redacted]

4)

[redacted]

4.3.2.4 QUALITY REVIEWS. (4.)

[redacted]

Table 4.3-28. Summary of HCBS Waiver Experience.

[redacted]

The Contractor shall conduct quality reviews in accordance with all State and federal requirements, as approved by the Agency.

[redacted]

5) [redacted]

6) [redacted]

7) [redacted]

8) [redacted]

9) [redacted]

10) [redacted]

Duties include but are not limited to:

HCBS Waiver and Habilitation Program Evidentiary Reviews (a.)

i. Coordinate the reviews with other IME Units and Agency staff.
ii. Review assessed needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans. The review shall determine whether:
    a) Services are individualized and reflect member's preferences and needs.
    b) Services are implemented as planned and produce the desired results.
    c) Members are safe and secure.
    d) Members are free to exercise their rights.
    e) Services strive to improve quality outcomes for members.
iii. Provide results of these reviews to the Agency for approval, prepared in accordance with the Agency's HCBS evidentiary materials guidelines, as approved by CMS.
iv. Provide a written review finding report to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the quality reviews, subject to Agency approval.

[redacted]

Figure 4.3-7. CMS Quality Framework for HCBS.

Our Quality Review aligns with this framework to support comprehensive reporting to CMS.

[redacted]

[redacted]

Community-based Neurobehavioral Rehabilitation Services (CNRS) Quality Reviews. (b.)

Community-based Neurobehavioral Rehabilitation Services (CNRS) Quality Reviews. (b.)

i. *All CNRS providers shall be reviewed over a randomized three year cycle.*
ii. *Review risk-based service needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans to determine whether:*
    a) *Members have a need for assistance*
    b) *Members have a qualifying brain injury diagnosis co-occurring with a DSM-V diagnosis*
    c) *Members have a standardized comprehensive neurobehavioral assessment documenting the member's need for services*
    d) *Members treatment plans are individualized and reflect the members needs*
    e) *Services are implemented as planned and produce the desired results.*
    f) *CNRS staff delivering or supervising direct service to the members meet the training criteria in rule.*
iii. *Coordinate the reviews with other IME Units and Agency staff.*
iv. *Provide a written review findings report of the quality review to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the quality reviews, subject to Agency approval.*
v. *Forward a copy of the report to the provider once approved.*

[redacted]

[redacted]

[redacted]

[redacted]

4.3.2.5 MINIMUM DATA SET VALIDATION REVIEWS. (5.)

[redacted]

The Contractor shall conduct annual MDS validation reviews of a minimum of 25 percent or approximately 110 of the current Iowa certified nursing facilities, to include but not limited to:

a. *Ensure every facility has been reviewed at least once within each four-year period.*
b. *Ensure facilities currently identified as being at-risk and those with the highest MDS error rates from the previous State fiscal year are given priority for reviews.*
c. *For each facility reviewed, conduct MDS validation on 25 percent, or a minimum of five, whichever is higher, of the Medicaid residents.*
d. *MDS validation reviews may be conducted remotely as desk reviews or on-site, if deemed necessary based on the complexity and professional opinion of the reviewer.*
e. *Ensure a minimum inter-rater reliability of 95 percent.*
f. *The validation review will utilize all pertinent information, including the MDS, the member's medical record, and interviews with facility staff.*
g. *Conduct exit conference with the nursing facility administrative staff to identify inconsistencies found in the MDS fields utilized for RUGs III classifications. The exit conference shall include MDS assessment with patterns of errors, areas that need improvement, staff education and training needs, and notice of when the final report will be sent to the facility.*
h. *Confirm Pre-Admission Screening and Resident Review (PASRR) was complete and appropriate documentation is included in the member's medical record.*
i. *Provide formal written report of the MDS validation process to the facility.*
j. *Notify the Agency if a nursing facility's error rate is greater than the established threshold or questionable patterns of coding or transmission are noticed.*
k. *Submit reports of MDS validation review activity and findings to the Agency on a quarterly basis.*

[redacted]

[redacted]

1) [redacted]

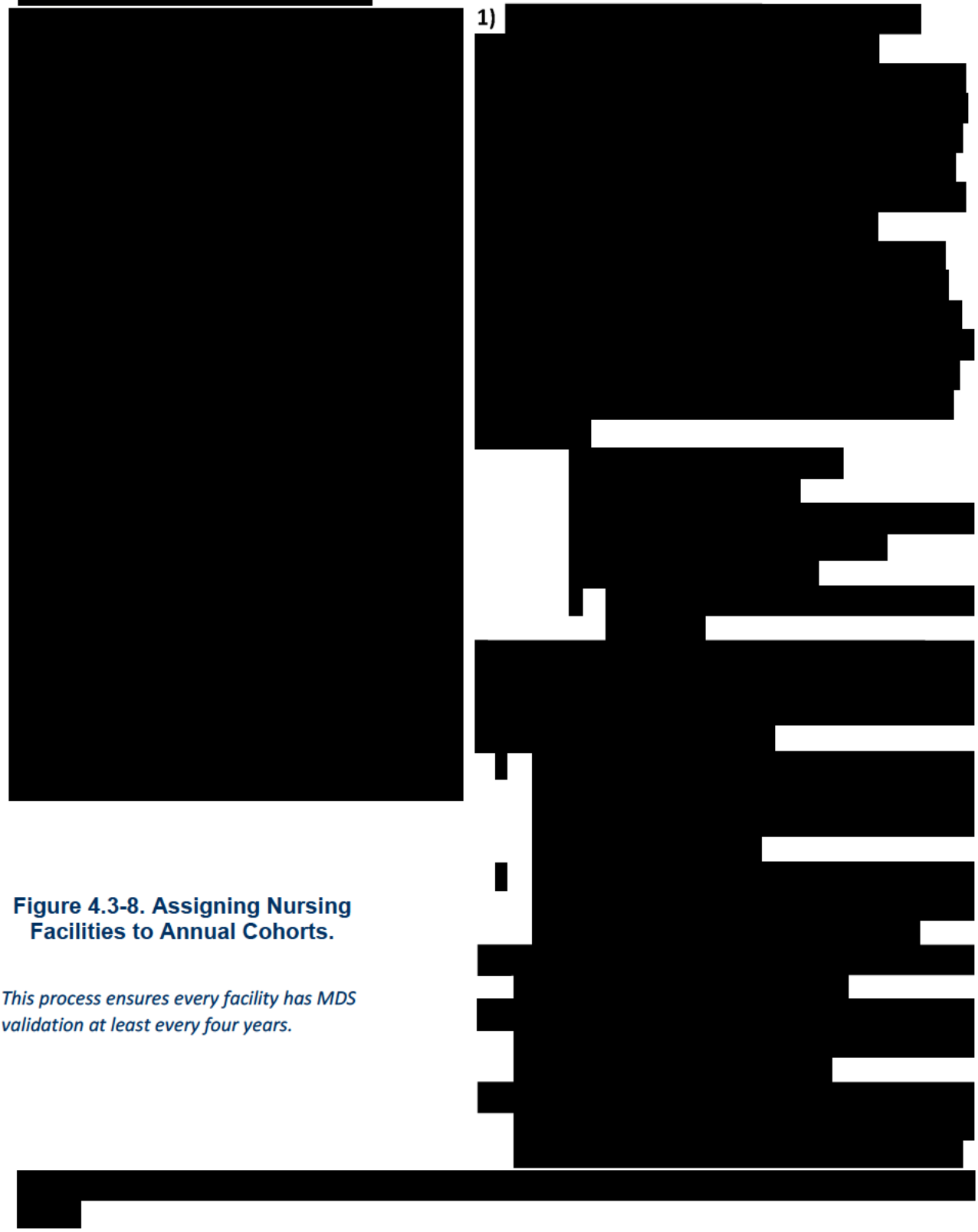


Figure 4.3-8. Assigning Nursing Facilities to Annual Cohorts.

This process ensures every facility has MDS validation at least every four years.

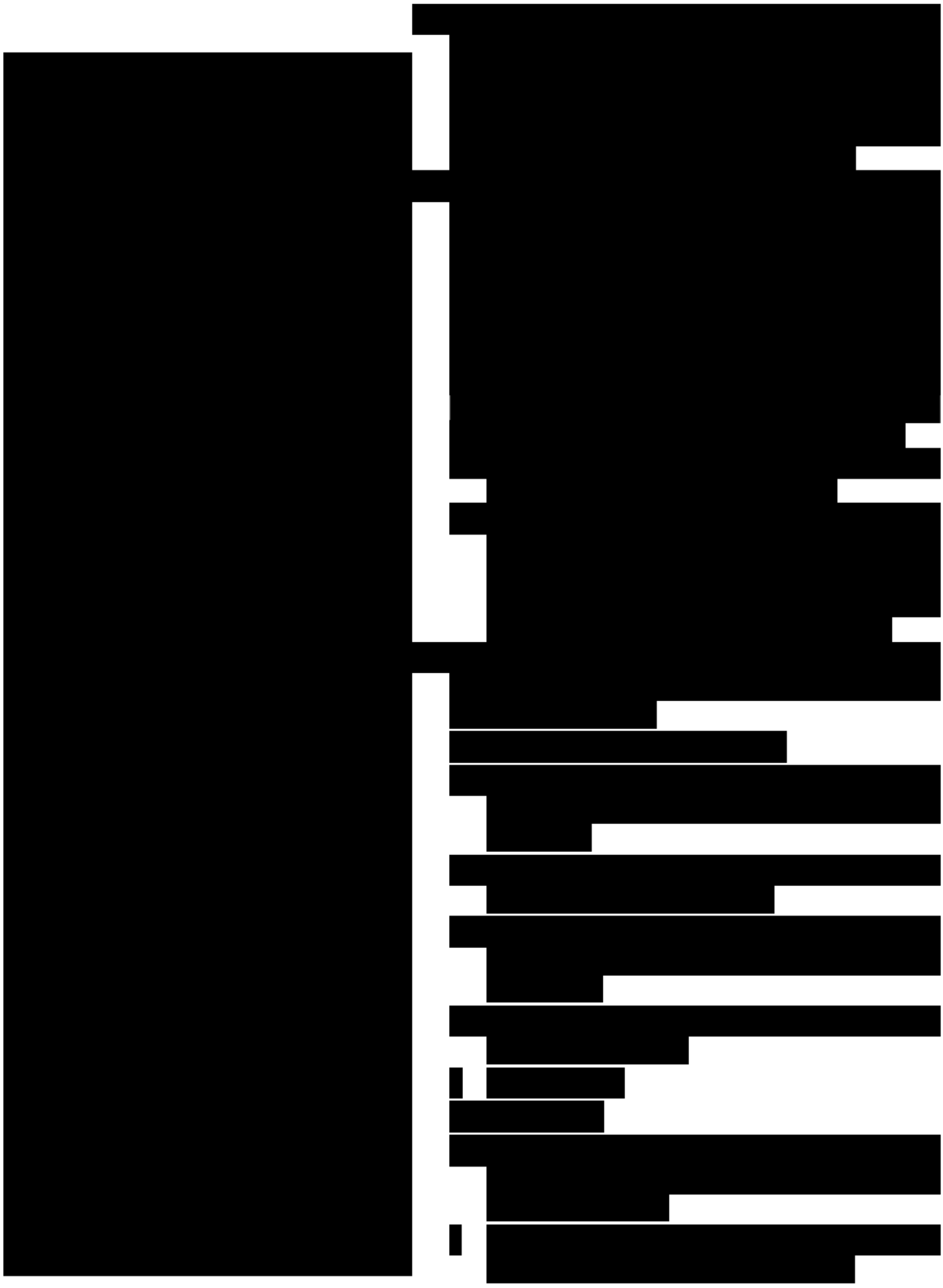


Figure 4.3-9. MDS Validation Process.

[redacted]

Inter-rater reliability (4.3.5.E)

[redacted]

4) [redacted]

[redacted]

4.3.2.6 UTILIZATION REVIEWS (URS). (6.)

[redacted]

Utilization Review

For the entire Medicaid population, the Contractor shall conduct UR activity in accordance with 42 CFR Part 456. Contractor duties include but are not limited to:

Facilities. (a.)

For ICF/ID, NF/MI, PMIC, and Mental Health Institute (MHI) facilities, evaluate the appropriateness of placement and that services are meeting the treatment needs of the member, to include but not limited to:

i. *Conduct an annual on-site review of current medical records for and observe members in the facility at the time of the onsite visit.*
ii. *Provide a written review finding report of the UR results to the facility, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the review.*
iii. *Report aggregate findings to the Agency on a quarterly basis.*

[redacted]

[redacted]

1)

2)

Table 4.3-29. Process to Conduct Facility Review/Inspections of Care

Our approach to this review uses our proven onsite process for efficient and reliable results.

3) [redacted]

[redacted]

Hospitals. (b.)

Hospitals. (b.)

For hospitals, evaluate utilization control processes to assess their comprehensiveness and verify their completion. Duties include but are not limited to:

i. *Conduct a triennial desk review of hospital utilization control process documentation.*
ii. *Notify the provider of the review results, including any identified deficiencies. This letter will sent to each CAH within three business days following review completion.*
iii. *Provide a written review findings report of the UR results to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the review.*
iv. *Report aggregate findings to the Agency on a quarterly basis.*

[redacted]

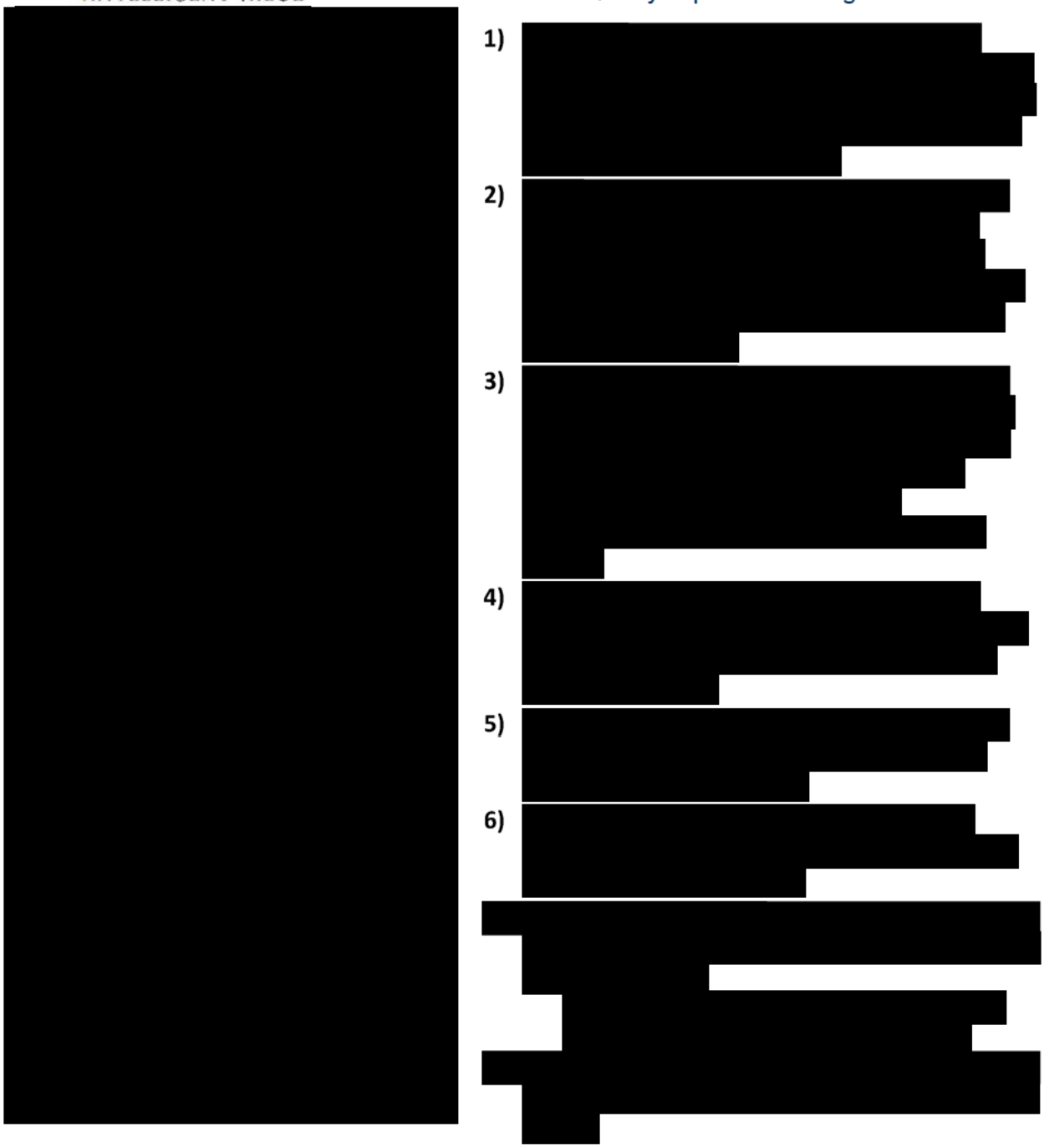
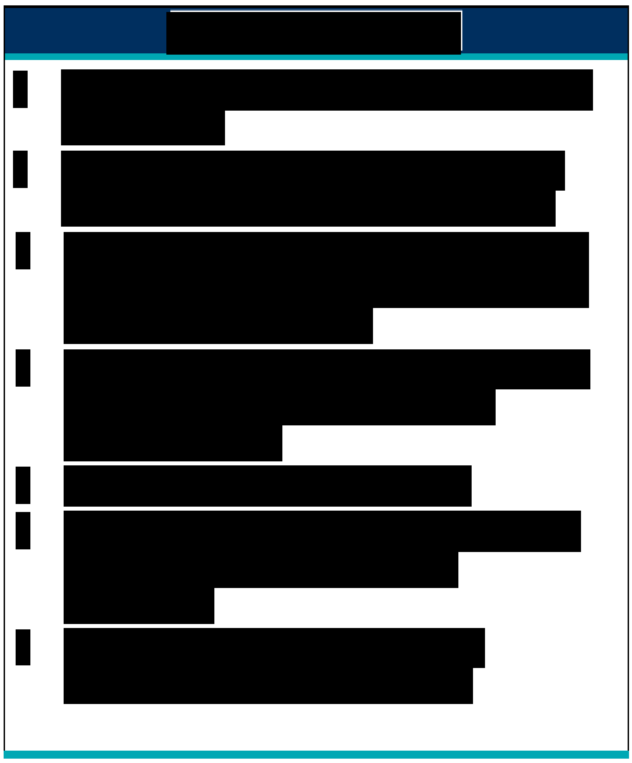


Figure 4.3-10. Hospital Utilization Control Plan Review Process.

Our oversight of hospitals in Iowa as part of the BFCC-QIO will help ensure a seamless transition for this function.

4.4 QUALITY OVERSIGHT OPERATIONS (1.3.1.4)

Quality oversight by our collocated team will ensure the IME has reliable findings and recommendations for program management and CMS reporting, backed by our effective staffing model that features over 90% staff retention, and experience earned through 21 current Medicaid contracts in 14 states.



Our state clients rely on our expert teams and more than a decade of experience to support their quality oversight of 19 waivers and other programs for 240,000+ enrollees. Our services vary depending on the state and specific waiver provisions. They typically include these responsibilities, documenting our readiness to assist with HCBS quality oversight:

- Objective assessment of waiver enrollees.
- Certification of providers to deliver waiver services.
- Data collection for and HCBS Quality Assurance reporting to CMS.
- Development of care plans and support for Independent Planning Teams.
- Review and authorization of care plans individuals and providers developed.
- Surveys to collect information on individual experience of planning and services.
- Provider quality reviews including validation of service delivery and consumer direction.
- Special and/or focused reviews of providers in response to complaints and incident reports.
- Development of corrective action plans and technical assistance and training for remediation.

In this section, we describe our overall approach to quality oversight of Iowa's waiver, Money Follows the Person, and Habilitation programs. This solution offers unique benefits to the Agency:

+ Efficient model that streamlines operations and reduces administrative burden.
+ Proven HCBS management techniques that meet CMS expectations for quality assurance.
+ Support for MCO transitions based on over 14 years of external quality review experience.
+ Advanced analytic capability to provide HCBS quality reporting in real time 24/7.

RESPONSE TO RFP ITEMS

4.4.1 GENERAL REQUIREMENTS (A.)

1.3.1.4 Quality Oversight Operations for HCBS Waiver, MFP, and Habilitation Programs
A. General Requirements
For requirements listed in Section 1.3.1.4, the Contractor shall:
1. HCBS Quality Assurance and Quality Improvement Recommendations.
Duties include but are not limited to:
a. Identify improvements to the technical and functional requirements of the HCBS waiver continuous quality improvement (CQI) process.

State and federal programs in four out of five states benefit from our CQI approach. We will implement the continuous quality improvement approach we describe in Section 4.1.5 for quality measurement and improvement across contract activities and deliverables. This strategy will make it more efficient for IME to review deliverables, interpret findings, and apply recommendations for program improvement.

Staffing training, policies and procedures, and in-depth knowledge of state and federal requirements of waivers is the foundation for our ability to recognize opportunities for improvement, together with a person-centered culture developed through our 20+ years of promoting independence and community tenure for individuals who use HCBS services.

The HCBS Reviewers, Clinical Managers, and Administrative staff identify improvements through:

1. **Requirements of Iowa's Waiver(s) and HCBS programs.** We train our staff in detail on the program requirements and regulatory framework for services. This training focuses on person-centered assessment and planning, integration of care across service types, and principles of quality measurement and improvement. They will recognize and document gaps between actual and expected services, beneficiary experience, and provider performance.
2. **Best Practices.** Our work with HCBS waivers began at the same time CMS began to allow them, and before that we worked with states to conduct external review of their 1115 Demonstration Waivers. Twenty years of experience in West Virginia and 10 years of experience in Maine and Virginia alone earned us our credentials implementing, managing, and improving programs. Our local service teams in 20 Medicaid contracts are resources to this contract, as we demonstrated with our legacy care management contract in Iowa, conducted as a subcontractor to Maximus.
3. **Application of operational experience and expertise.** Our HCBS quality staff are experts in their fields and understand Iowa's HCBS programs. With direct experience as service providers, they have a "real world" understanding of how operations work, and know where there are opportunities to improve both policy and practice.

b. Make recommendations to the Agency that identify system improvements and best practices in quality assurance and quality improvement within the HCBS waiver, Habilitation and MFP programs.

We design every part of the quality system to capture information that promotes our ability to make recommendations to improve systems and practice. From training, to forms, to reports we engineer an efficient process to discern opportunities, distill our findings to recognize patterns and trends, and develop practical recommendations. These recommendations will be realistic and reflect meaningful opportunities for improvement. Just as important, we will also be able to deliver technical assistance and provider training to help them implement improvements and sustain improved performance.

Our Recommendations Process and Methods mirror the National Institute for Health and Care Excellence (NICE). This process of developing the research recommendations is robust, transparent and involves stakeholders.

Table 4.4-30. Process of Systematic Reviewing

IME will benefit from our synthesis of evidence primarily through the process of systematic reviewing and, if appropriate, modelling and cost effectiveness decision analysis.

[redacted]

KEPRO will continue to make recommendations for criteria development and revision throughout the life of the contract. Priorities shall be determined by ODM during monthly status meetings. In addition, we will provide Medicaid with suggestions for areas requiring modifications. These suggestions will be generated from:

- Input we received from our physician reviewers. Our policy is that when performing case review, a physician reviewer must cite medical evidenced-based literature when making recommendations as supportive documentation if they are going outside of the decision support criteria recommendations.

- Data analysis uncovering over utilization of services and what the costs associated with that over utilization to the program are. We have been providing these types of reports across all our utilization management contracts throughout out our 30+ year history.
- New diagnostic tests, therapeutic procedures or medical devices for which other good alternatives do not exist
- New technologies that are considered life-saving
  - Medical technologies that are controversial with respect to their clinical utility
  - Medical technologies that have generated a high level of interest for members and/or providers
  - New information is available in the peer-reviewed scientific literature that may change the status of a technology from investigational to medically necessary.

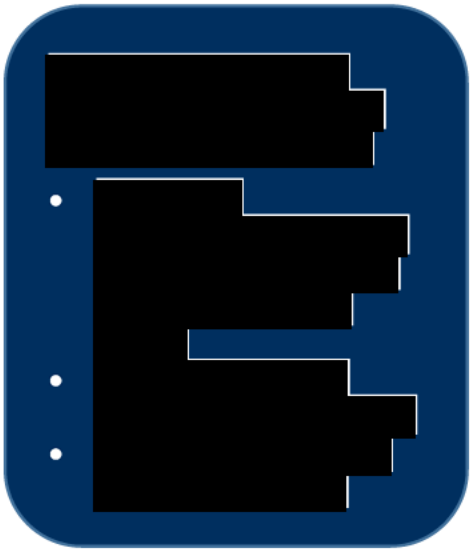


Table 4.4-31. Clinical Review Criteria, Information Sources, and Processes

Our Health Intelligence team will support this contract with a dedicated Data Analyst as well support from corporate staff for standard and ad hoc reports. We propose our innovative reporting system in Section 4.1.6 that will enable us to base recommendations on accurate, timely, and complete data. The Agency will be able to access these reports 24/7 online through our Health Intelligence Center, including drilling down to the detail level to examine individual records that contribute to patterns and trends.

Our clinical management team and analysts will review the data and findings, evaluate opportunities for improvement, and make recommendations for policy and program changes to implement improvement. We used these techniques in our recommendations for reports, which we describe in Section 4.4.1.e.

c. Collaborate with other IME Units to make recommendations to the Agency that recommend policy revisions based on identified quality indicators.

The Agency's requirement to embed staff with IME aligns with our experience and our local service center approach. We currently conduct two programs for IME through an embedded model. This model provides exceptional opportunities to collaborate with other units and staff members, and we will use this approach to work with other IME units to examine quality indicators and develop informed recommendations for policy revisions.

d. Report findings to the Agency on a quarterly and annual basis.

The quarterly reporting process is how we compile results and identify the trends and patterns that represent opportunities for improvement. Reports need to be reader-friendly; organized to highlight findings; and make meaningful recommendations to the Agency. In 4.4-**Error! Reference source not found.** we show our proposed quarterly report template. Our response in Section 4.4.4 includes an example of a report, based on HCBS reports in the Bidder's Library, that illustrates the benefit of our reporting approach.

Reports that require evaluation and discussion of findings and formulation of recommendations at the program and policy level. It is also appropriate to report summaries of activities to convey the volume of work during the reporting period. For this type of report, our suggested format is in Table 4.4-32. This template is appropriate for summaries of prior authorizations, completed IPES surveys, incident reports, etc. including the number of activities completed and timeliness of the work. Reporting for the Performance Measures will also use the format in Table 4.4-32.

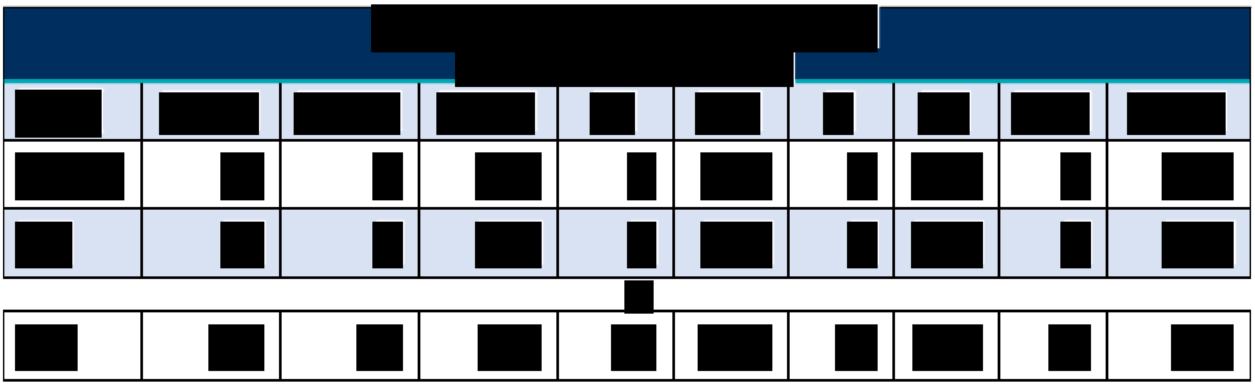
Regardless of the type of report, the essential characteristics of the format remain the same:

- ✓ Shading to differentiate report lines.
- ✓ Adequate spacing and font sizes for enhanced readability.
- ✓ Use of percentages and/or benchmarks and baselines to provide context.

- ✓ Numerators and denominators on the page to allow reader validation of rates.

Table 4.4-32.Format for Monthly Summary Reports.

Assuring reader-friendly report formats will make it easier for the Agency to monitor performance.



PRELIMINARY REPORT RECOMMENDATIONS

After reviewing the quarterly reports for HCBS Quality, we offer recommendations to improve the usefulness and readability of the reports:

1) **Summary**. As we propose, the report should have a section that summarizes overall findings and recommendations. We did not see many conclusions or recommendations in the four quarterly reports in the Bidder's Library, and we recommend that an introduction be in every report that presents the overall results for the quarter, recommendations based on those results, and the rationale for the recommendation. The last quarterly report should also summarize the overall results and recommendations for the annual period.

2) **Context**. Raw numbers usually need a context, such as quarterly rates for results or comparison to benchmarks. In this case, charts and graphs that include the percentages would improve the usefulness of the data by making it possible to interpret the magnitude of the findings and observe patterns and trends. Reporting only whole numbers makes it difficult to identify issues. Additionally, it should be clear if the number of occurrences, such as claims or incidents, represents unique individuals or if individuals could be reported in more than one category.

3) **Formatting.** We noted in the reports as a whole that numbers are typically not right justified. Right alignment helps to show the differences between results – for example, the differences between 15 and 150 are more evident when the cell is right justified. We also suggest including both tables and graphs that include percentages and totals to make it easy to visual patterns and trends.

We reviewed the last HCBS quarterly quality assurance report (SFY17 Q4 QA Report.pdf) in the library in depth and analyzed the data on page 11, All Major and Non-Major Incidents. We discuss it in Section 4.4.4, Incident Report Management, as an example of our recommendations for these and other reports. We are not able to show the results of drilling down into the detail for each category, which would enable us to develop actual recommendations. Instead, we formulate recommendations based on our decade of experience with HCBS programs and typical issues that result in reportable incidents.

PROGRAM REPORTS

The specific content of reports will vary according to the program feature and timeframe, e.g., monthly, quarterly, or annual. However, developing a common format and overall structure helps make it easier for IME to find actionable information and interpret results.

The Health Intelligence staff will program dashboard summaries for reporting purposes as well as availability on the Health Intelligence Center, with program staff interpreting the results and developing recommendations based on findings. The Program Director will be responsible to submit reports to the Contract Monitor for IME and will act as the point of contact for discussions and questions.

HCBS Website.

Current, accurate, and complete program information, available always and everywhere is an essential requirement for quality improvement and program compliance. With an uptime of over 99% for our websites, we deliver this information to providers on demand.

2. *Duties include but are not limited to:*
    a. *Provide rule hyperlinks that explain processes related to provider quality oversight.*
    b. *Provide an updated list of provider training schedules.*
    c. *Provide updated list of staff to include the Program Supervisors and all Specialists with county assignments, a telephone number, and email address.*

Providers will be able to view the training schedule as well as enroll in training programs using the HCBS website. Providers can identify sessions of interest and register online through the website.

A unique feature of our solution is our ability to leverage years of training development for programs in Illinois, Pennsylvania, and West Virginia for HCBS providers to improve safety, compliance, and quality for individuals in waivers and other programs.

We will feature a staff listing on the "Contact Us" page that includes Program Supervisors and Specialists with county assignments, and include their telephone number and email address. Since this type of information is subject to change, we will create a resource where these staff members can update their own information, which the system will publish. In addition, we will monitor the listing manually to assure that the information is current and complete, and we will routinely update information available on this page to make sure it is accurate. We will maintain program level contact information on this page as required by the State, including telephone numbers and email addresses.

    d. *Establish, develop and maintain a continuous FAQ link containing information approved by the Agency SMEs.*

We maintain pages for frequently asked questions so providers can access important information quickly and easily.

The Iowa Medicaid QIO website will include a link to FAQ documents that provide approved information. Working with Agency SMEs, our local QIO team will prepare the content for the FAQs. The Web Manager will be responsible to post the updated documents once the Agency approves. We will update these documents when the information changes or new information is available, using our Call Center documentation to identify questions and issues that are "frequent" enough to include in our FAQ materials. Since HCBS information can encompass a variety of topics, we suggest maintaining several FAQs to ensure information is easy for users to access online.

e. Provide all other information, to be determined by the Agency, on a timely basis.

Our combination of dedicated, embedded, staff and corporate resources gives the Agency flexibility in information requests, and ensures that our response is timely. For example, in our Maine program, we respond to over a dozen requests for special reports, studies, and materials on a monthly basis – and all of them are accurate and timely. The Project Director will be the point of contact for requests, and will assign appropriate staff to respond.

When we receive a request, we will document the date, nature of the information request, and Agency timeframe for response.

f. Contractor shall update Agency-approved HCBS waiver dashboard on a monthly basis.

Our Iowa HCBS team will work with the Data Analyst and other HI staff members to update the HCBS dashboard on a monthly basis at a minimum. Our clients need information updated in real-time and accessible everywhere, 24/7. For this reason, we developed our Health Intelligence Center Online Dashboard system, which we customize for each contract.

This system features charts and graphs for selected performance measures relating to contract activities and system performance. Dashboards can include, for example:

- Scheduled and completed Provider Reviews by waiver.
- Results of member experience surveys, such as the IPES.
- Providing training attendees by topic and evaluations of training sessions.
- Incident reports and analyses.

g. Report activities to the Agency on a monthly, quarterly, and annual basis.

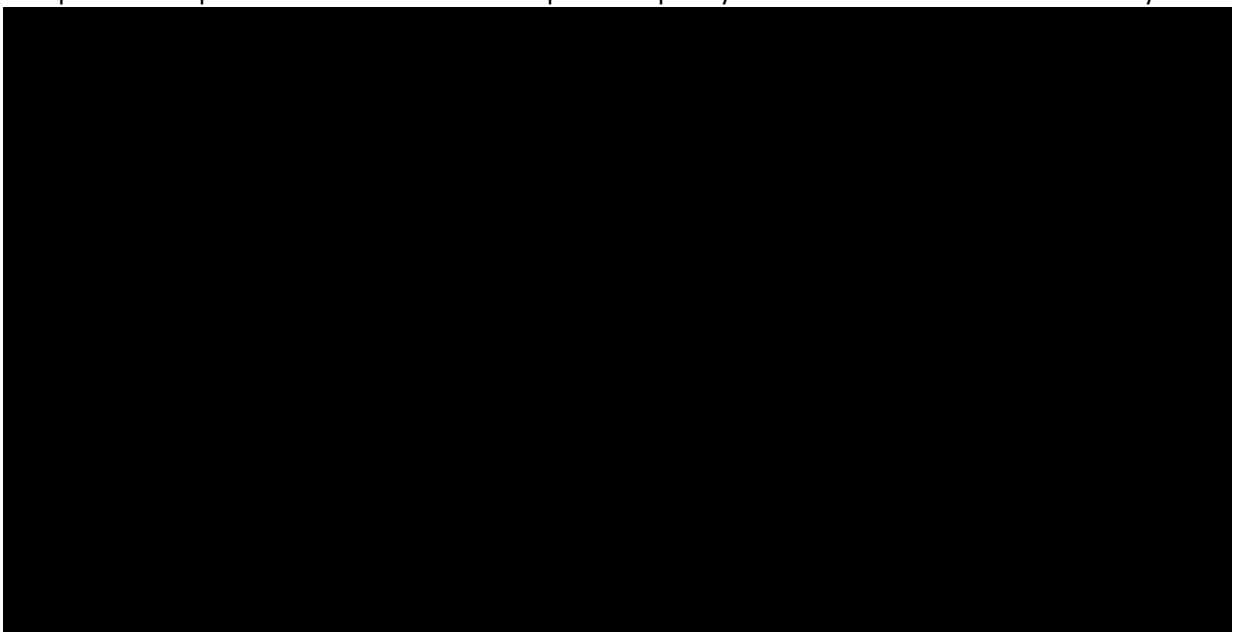
We will generate reports on a monthly, quarterly, and annual basis, with the dashboard reporting system updated in real time based on updates to the underlying variables. Our local data and analytic staff will be responsible to compile data from the various IME systems and consolidate it into our reporting database, and will conduct this activity on a weekly basis. Working with the Agency during transition, we will develop the approved format for reporting, and implement it for accurate operational reports.

Table 4.4-33 presents a graphic website dashboard that describes key metrics of performance for our websites.

Table 4.4-33. Website Reporting Dashboard.

We track and report all standard website traffic measures for our main sites and client sites.

As we show in Figure 4.4-24, we track sessions (visits) to our websites by program. In total, during the third calendar quarter of 2017, there were 151,850 visits to our websites. The average time on site varies, depending on the website. Visitors can access program rules, CMS requirements, and submit questions and concerns. By comparison, the average time on our Ohio PASRR website was approximately one-third of that time. On this website, the typical visitor moves to the links page, and then accesses information about provider requirements. This structure helps them quickly reach and use the information they need.



We track and report key metrics on website functions to manage websites effectively.

3. Administrative Support.

Collocated teams provide the opportunity to integrate Contractor staff with Agency staff for improved coordination and communication, and a seamless management team for stakeholders. Collocating our team with the Agency will provide easily accessible administrative support. Local service centers and embedded operations are a KEPRO best practice, and we maintain 15 local offices across the country that provides administrative and operational support to our clients. In addition, we staffed the care management function for Iowa with collocated employees as a subcontractor to Maximus prior to managed care implementation, and currently maintain collocated operations for two IME programs.

Duties include but are not limited to:

a. Complete any clerical and administrative functions associated with program administration of services, as assigned by the Agency.

We act as an extension of Agency staff, working as assigned by our clients to support their clerical and administrative functions. We include 50.02 FTEs for this purpose in the current program. To provide the maximum support for the Agency in terms of quality and efficiency, our administrative staff will have these credentials:

- Two-year degree in business or office services, with a four-year degree preferred.
- At least two years of experience working in an office environment, with preferred experience including the following, for example:

- Administrative/Clerical work with the Iowa Medicaid Enterprise.
- Administrative/Clerical work in Medical/behavioral health/social services settings.
- Proficiency with Microsoft Office.
- Ability to use typical office systems such as desktop computers, telephone systems, laptops, and fax machines.

During Transition, we will complete the hiring process, and train employees on Agency systems and requirements. These staff members will report to our Operations Manager who will work collaboratively with Agency staff to ensure we meet their administrative and clerical needs.

e. Prepare for and assist the Agency with audits/renewals and reviews related to the provider quality assurance oversight data.

Our HCBS team will provide comprehensive support to the Agency for its HCBS Quality oversight functions. This support includes helping to manage the audit and renewal process for provider quality reviews, which we describe in greater detail below. In addition, we will assist the Agency with compiling, reviewing, and validating quality assurance data for reporting to CMS.

f. Resolve billing problems.

Training for our Customer Service Representatives (CSR) will include detailed training on billing procedures for HCBS services. The CSRs will have access to the billing system, and work with providers to research and resolve billing problems. They will also log these calls by program, type of problem, and provider type, so that we can analyze problems and develop training, FAQ documents, and other resources to help providers avoid billing problems.

g. Assist with SOP and provider manual updates.
h. Maintain a resource guide.

Our Transition approach will include reviewing the Standard Operating Procedures (SOP) and provider manual, and updating it as needed prior to go-live. These materials will be available on our HCBS website and available in hardcopy format for providers who may have limited access to the electronic version. Thereafter, we will use a formal process each quarter to review and update SOPs, provider manual, and resource guide. We will also automatically update these materials when the Agency issues changes in rules and procedures. The Project Director will submit them in draft format for Agency review and approval. Once approved, we will post the updates to the website. We use a “Hot Topics” banner highlight and link to important notices.

Table 4.4-35. Landing Page Example for Virginia Medicaid Utilization Review Program.

We publish announcements on the program home page so providers can easily identify topics of importance.

We currently maintain independent websites for 12 state and federal programs, including services that we will provide in Iowa such as HCBS quality assurance, utilization review, provider audits, etc.

i. *Review and determine approval for assigned applications for new HCBS providers, to include but not limited to:*
   i. *Review to ensure applications are complete;*
   ii. *Send notification to providers of the requirements and documents needed for becoming a Medicaid HCBS waiver provider;*
   iii. *Conduct a desk review of provider application and documentation to determine if application can be approved; and*
   iv. *Notify IME Provider Services unit, as applicable.*

The HCBS Specialist and HCBS Support Assistant will conduct this review process, shown in Figure 4.4-11

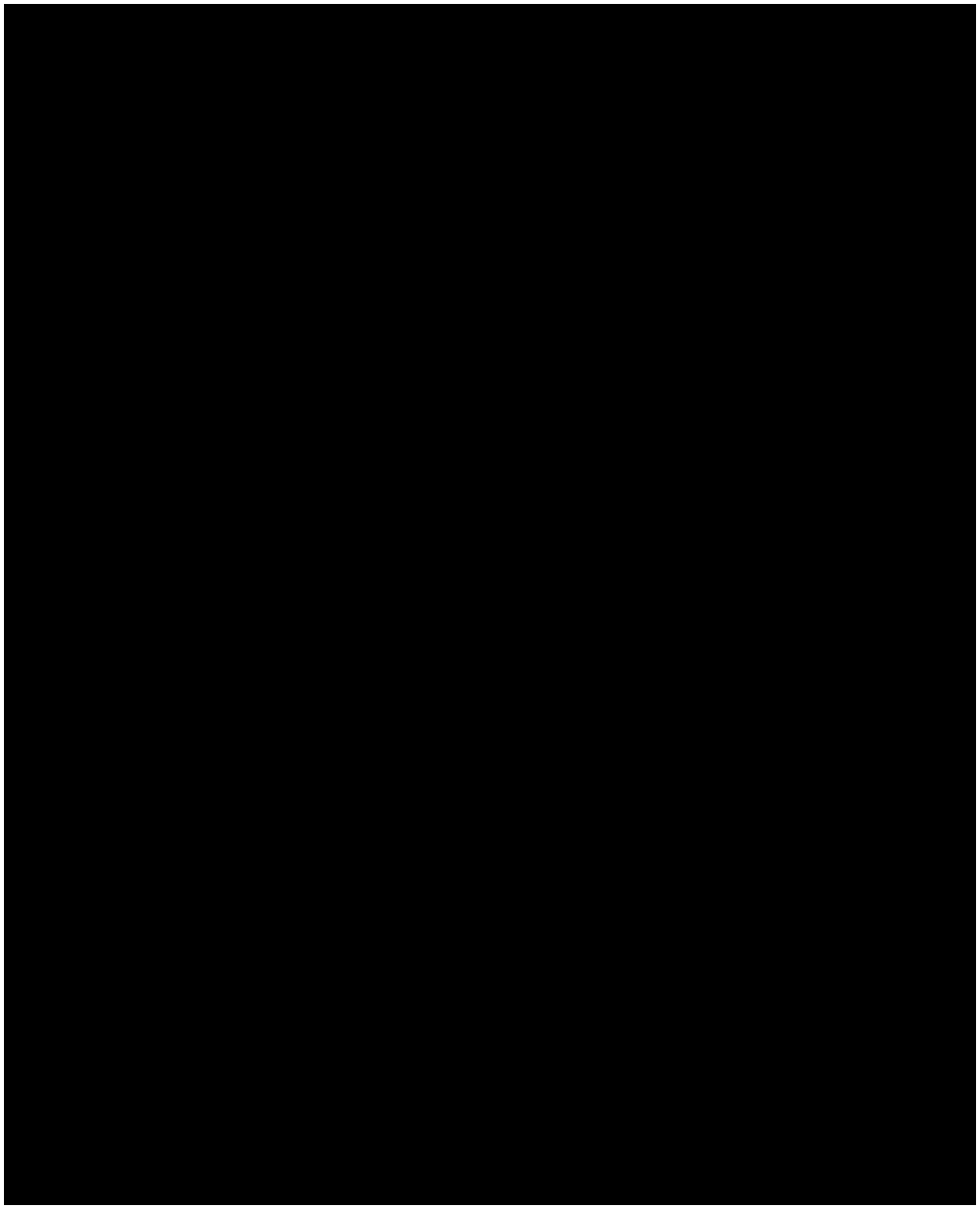


Figure 4.4-11. Overview of HCBS Provider Application Review.

HCBS Staff will provide compliant, efficient and provider-friendly review and technical assistance to new providers.

Our process follows the procedures included in the HCBS – HCBS Quality Oversight Certification Review Process, including these 8 steps:

1) **Application Received**. The HCBS Specialist will review the provider application in OnBase.

2) **Evaluate Application Completeness.** The HCBS Specialist will verify that the application is complete.

. If there are errors or omissions, the Specialist will contact the provider for corrections to the application.

3) **Receive and Validate Review.** If the application includes HCBS services, HCBS support staff will send the provider a notification that includes identifying the materials needed for

New Provider Checklist

i. Identification of Board Members
ii. Policies and Procedures
iii. Owner and Staff Background Checks.
iv. Evidence of approved curriculum in Child and/or Dependent Adult Abuse Reporting.

4) **Conduct Desk Review.** When the HCBS Unit receives the materials, the HCBS Specialist will conduct a desk review.

5) **Specialist Reviews Materials.** If there are issues or errors with the materials, the HCBS Specialist will contact the provider for technical assistance regarding Iowa Administrative Code (IAC), 42 CFR Subpart G, Home and Community-based Services Waivers, background checks, Board materials, or expected policies and procedures.

6) **Complete?** If the Application is complete and meets the requirements for new providers, the HCBS Specialist will issue a 270-day certification.

7) **Notify Provider and Provider Services.** The HCBS Specialist will notify the Provider and IME Provider Services.

8) **Document Results.** The HCBS Specialist will document all process and materials in the Quality Assurance Performance System (QPS).

g. Provide assistance to providers and field staff on specified program issues as approved by the Agency.
h. Work with the Agency and other IME Units on identified issues.

Our HCBS team will be available to work on issues that the Agency identifies as well as with other IME Units. Our ability to collaborate on cross-cutting solutions provides depth to issue resolution and helps to ensure that remediation is effective and sustainable.

For example, one of our reporting example recommendations was to collaborate with other IME Units to develop a quick reference guide to reportable incidents to improve accuracy. We also recommend working with the Pharmacy Benefit Manager and MCOs on medication management, for example, in response to our "finding" that medication issues were underlying factors in mental health crises and law enforcement engagement.

i. Report activities to the Agency on a quarterly and annual basis.

Quarterly and annual reports will follow the format we recommend in subject to Agency approval.

4. Provider Training.

Training and Technical Assistance return value to the program by reducing provider administrative burden and improving compliance – and are a focus of our programs across the country. The success of the more than 30,000 Medicaid providers who deliver services we oversee on a *monthly* basis depends on our proactive training and exceptional customer service. We exceed the expectations of our clients, as a mental health provider in Maine commented:

> *"They go above and beyond to provide training when called upon and have attended local team meetings and monthly check ins to see how we are doing navigating the system. They remain open to feedback and demonstrate professionalism in their transactions with our agency staff." – Michael Milanese, Contracting Officer, Centers for Medicare & Medicaid Services*

The Agency can expect the same level of professionalism and openness in our approach with Iowa's HCBS providers, MCOs, IME Units, and other stakeholders.

Duties include but are not limited to:
a. Develop and conduct training in collaboration with the Agency's MCOs;
b. Various methods of training dissemination including web-enabled training for providers as approved by the Agency.

HCBS providers include large and sophisticated organizations as well as very small businesses. Our role is to help assure that all providers have the information and training they need to deliver compliant, person-centered HCBS services to help individuals achieve their goals. As part of our on-going

collaboration with the MCOs to ensure providers and members receive quality services, we will develop training programs and deliver training with the MCOs. We propose to establish working meetings on a monthly basis to discuss scheduled activities for the upcoming 30 days, identify training and technical assistance needs, and coordinate quality activities. This process ensures that IME Contractors present a unified, person-centered, and coordinated approach to quality oversight.

TRAINING METHODS

Providers prefer training available through web-enabled programming and materials. It avoids costly travel, and makes needed information available on a 24/7 basis. We customize our training programs and methods for each contract to deliver training that best meets the needs of the provider community.

The following figures and discussion uses our Administrative Services Organization (ASO) program in Maine as examples of our training approach. This ten-year old contract illustrates the benefits of our approach, which include attention notices on the home page; special resources section including training; and variety of online, downloadable, and recorded training. It is an "on demand" site for Maine providers.

The Maine program focuses on behavioral health, support for health homes, waiver wait list management, consent decree support, and collaboration with other MaineCare vendors, including the MMIS and PBM.

Providers can use relevant training programs through 24/7 access to our website.

c. Interpretation, clarification, and guidance on procedural expectations of State and Federal regulations and administrative code, as well as industry accepted standards for best practice.

Our clients expect us to be the central clearinghouse for accurate and timely information. Our local team is responsible to provide interpretation, clarification, and guidance on regulatory requirements, including administrative code and the Code of Federal Regulations.

Local teams have the support of corporate departments, including Quality Improvement and Compliance, to ensure we provide the most accurate and up-to-date information on state and federal regulations. Our staff members are easy-to-access local resources for this information. The Agency will be able to contact the Project Director, as the point of contact, for information. The Agency may also conveniently contact any of our HCBS program specialists.

Just as important is access to clinical and operational best practices. As the Beneficiary and Family-centered QIO for Iowa and 33 other states, we have a network of 3,500 medical experts in all specialties. These Board-certified specialists are resources to identify best practices in their respective fields. We also identify best practices through evaluation of our 19 Medicaid programs for utilization, care, and waiver management for medical, behavioral health, and IDD services. Our ability to share information across programs provides access to individuals who are operational experts in their fields. With these extensive resources, our collocated Iowa team can be the Agency's local experts for regulatory, operational, and clinical information to improve efficiency and quality.

d. Focus areas based on HCBS quality assurance processes and supported by Contractor data analysis, subject to Agency approval.

Over 90% of providers report they are satisfied or very satisfied with our training. This score means that the training is relevant, convenient, and focused on areas that improve provider performance without increasing administrative burden.

Table 4.4-36. Quality Improvement Cycle for Provider Training

Using quality assurance, utilization, and review data to focus provider training results in a data-driven approach that improves performance and provider experience.

The Health Intelligence team will work with the Agency and local operations on analysis of program data, including these data sources:

- Provider requests for training and technical assistance.
- HCBS Quality Assurance data, including for example, findings on person-centered assessment and planning; health and safety; and provider performance.
- Provider Reviews, including best practices and system level issues.
- Utilization claims and encounter data from the MMIS and MCOs, to identify patterns and trends of HCBS utilization, and where possible, compare access and utilization between payment systems.
- Results of HCBS Waiver and program enrollee survey results.
- Incident reporting statistics and investigation results.

On a quarterly basis, we will compile the results of our data and program analyses, and identify opportunities to focus provider training on prevalent issues. In addition, we will provide proactive training for updates to program operations, changes in Agency policy, and/or state and federal regulatory changes.

The HCBS Manager will be responsible to work with HI and the Agency to prioritize training topics, and develop training programs that address those topics. We will then develop webinars, FAQ documents, presentations, and other training media for review and approval by the Agency. Once approved, we will develop the quarterly schedule for training, and notify providers.

Our experience shows it is important to use multiple and alternative methods to communicate the availability of training to reach all interested providers. We use these methods to reach providers:

- Notices on the HCBS and general websites.
- Reminders through the Call Center when providers contact Customer Service Representatives.
- Work other provider-facing vendors to publicize training, such as:
    - MCOs to include training notifications on their websites and provider newsletters.
    - MMIS to include training notices on its website and in claims communications.
    - Provider organizations, such as the Iowa Association of Community Providers, to feature the training schedule on their website and in communications.

A benefit of working with our team is our extensive training library for HCBS providers from our programs in Pennsylvania, West Virginia, Illinois, and Virginia.

[redacted]

Because we support waiver programs that serve over 220,000 enrollees, we understand critical issues that affect members and prevalent needs of providers for training that improves quality assurance results. These training programs represent a foundation of material for an efficient transition to quality oversight.

e. Coordinate with other IME Units to develop and deliver provider training tools and reference materials.
f. Identify system improvements and best practices in provider training.
g. Report activities to the Agency on a quarterly and annual basis.

Presenting a unified message and training approach is essential to effective training and avoids creating confusion for providers. We will coordinate training with Provider Services and other IME Units for provider training. We propose to conduct regular meetings with IME Units (if they do not already occur) to facilitate coordination with their activities and resources. Our work for Medicaid routinely requires coordination with Aging and disability, behavioral health, IDD, and other state agencies in 19 states. We earned reputation for being easy to work with as a Contractor – including being flexible and provider-friendly – through 20 years of Medicaid contracts that current engage with over 37,000 providers and 29 million Medicaid members.

This collaboration enables us to make recommendations for improvements at the system level, as well as identify best practices in provider training among IME units as well as other Contractors, such as the MCOs. Since most of the population is or will be enrolled in managed care, it is practical and efficient to ensure close coordination with the MCOs for training to avoid conflicting information and a burden on providers to participate. Coordinating feedback and training with these organizations then makes our ability to identify system improvements stronger and statewide.

[redacted]

We will report to the Agency on a quarterly and annual basis. Content will include the number of training sessions offered by training method; number of attendees; and results of training evaluations. We will also provide recommendations for improvements in training processes, and suggestions for additional training topics.

5. Log all provider reviews, complaints, incidents, and surveys into the current Agency electronic tracking database, to include discovery, remediation, and improvement activities. Duties include but are not limited to:
a. Associated data shall be stored for no less than ten (10) years.
b. Data shall undergo internal quality checks by the Contractor to mitigate data entry errors.
c. Present an internal quality assurance analysis to the Agency on a quarterly and annual basis.

HCBS Project Assistants and HCBS Specialists will be responsible to data entry into the relevant systems, such as ISIS and MQUIDS (and other systems as relevant, such as WISE for slot management). This information will include results of reviews, training evaluations, flags from surveys of waiver members, etc. The corporate Information Technology team will maintain data we store in proprietary systems for a minimum of 10 years. Our systems meet Department of Defense standards for security and confidentiality, and we have a Business Continuity Plan that protects data in the event of catastrophic events.

DATA QUALITY ASSURANCE

We have security and confidentiality procedures that will meet Iowa standards and ensure we protect data from internal and/or external threats to data quality. Additionally, we assure the quality of data through a formal process of data validation, which we show in 4.4-Figure 29, and describe below as a seven-step process.

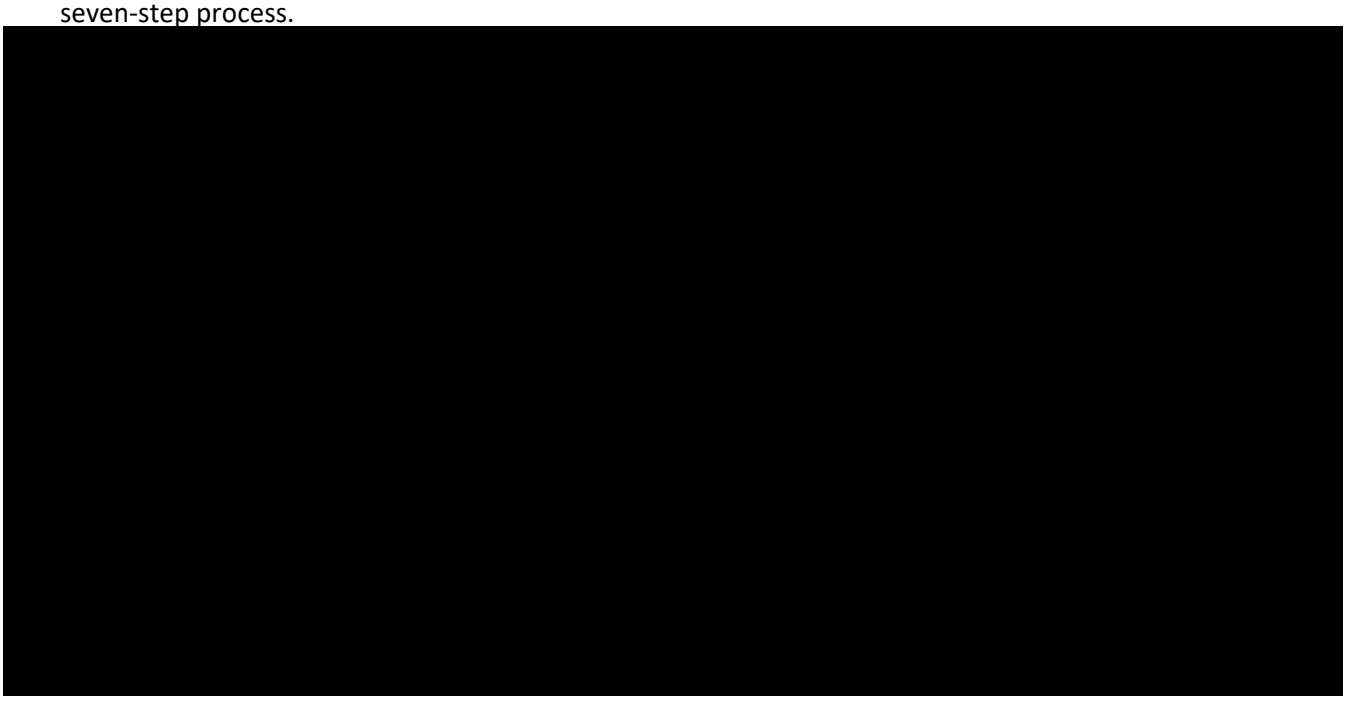


Table 4.4-37. Quality Assurance of Data Elements.

Our structured process identifies errors at three critical checkpoints, corrects them, and prevents them through corrective action and training.

1) **Data Entry**. We will receive information for data entry, and complete entry into IME systems and/or local systems according to the type of information. For example, we will enter Provider Reviews into the MQUIDS and maintain waiver slot tracking in WISE. Survey results will be maintained by HCBS Specialists in a local data application.

2) **Immediate Validation**. This process entails checking the data in the system with the source data, and occurs immediately after data entry. HCBS Project Assistants will conduct this process for most of the entered data, with HCBS Specialists and the HCBS Operations Manager conducting immediately validation for other information, such as survey flags. If we identify errors through this process, we correct them and log the type of error for later analysis.

3) **Weekly analysis and validation.** Data errors create anomalies in the data values that we can identify through analysis of the data contents. We will analyze the data on a weekly basis for

consistency of content to identify things like misspellings, incorrect demographic values in text fields such as name and address, and other content errors. We will correct and log these errors.

4) **Monthly Sample**. Monthly, we will select a random sample of data records entered during the prior month, stratified by data system and user if relevant. We will generate a listing of records to validate and assign them to staff members. HCBS Specialists will review records for other staff, and the Operations Manager will also conduct review to assure that staff do not review their own records. The review consists of evaluating the record against the original information to ensure we entered it correctly. We will also log errors we identify through this process.

5) **Analysis of Errors and Error Report**. On a quarterly basis we will profile the results of data validation to identify system issues, such as the need for a field edit in a system, as well as the need for individual staff training and changes to policies and procedures.

6) **Policies & Procedures**. We will update policies on a draft basis for submission to the Agency for review and approval, and provide training on changes prior to implementation. We will also conduct training for providers if we identify patterns relevant to provider behavior.

7) **Training.** In addition to training for individual deficiencies that created data errors, we will also provide training related to changes in policies and procedures and overall training on data entry procedures, as relevant.

The results of our data validation processes will be reported to the Agency on a quarterly basis.

6. Provide statistically valid and reliable processes to include but not limited to:
a. Samples, reviews, tools, and techniques shall be evaluated for statistical validation and reliability.
b. 100% of processes should be included in all relevant SOPs and maintained at an annual basis to ensure accuracy.

Our samples, reviews, tools and methods generate findings that can have an effect on the medical care, behavioral healthcare, and social services for over 82 million Americans through state, federal, and military programs we manage. The magnitude of this affect means it is essential for all aspects of our operations to be valid, reliable, and transparent.

We achieve these outstanding results by including 100% of all processes in standard operating procedures (SOP) that align with our URAC accreditation requirements. URAC policies and procedures are the responsibility of the corporate Quality Improvement Department, which works with our contract teams to develop Local Operating Procedures that comply with contract requirements.

We reviewed the policies and procedures located in the Bidder's Library, and are prepared to assume responsibility to update and maintain these and other documents as required by the Agency. Updates will include a formal review on an annual basis. Additionally, we will review the procedures and update them on an ad hoc basis, in response, for example, to regulatory changes or results of quality improvement activities that result in changes to the processes they document. The Project Director will be responsible to ensure the Agency reviews SOPs in advance and approves changes prior to implementation.

4.4.2 HCBS PROVIDER REVIEWS (B.)

B. HCBS Provider Reviews

The provider review process is the foundation of quality oversight for home and community-based services. Our experience includes over 20 years of onsite and desk reviews for HCBS and behavioral health providers, and focuses on these benefits to ensure that providers can use results to improve performance:

- ✓ **Experienced and qualified reviewers with appropriate licensure**. For example, in West Virginia, licensed social workers with backgrounds in HCBS for individuals with intellectual or developmental disabilities conduct audits of IDD waiver providers. In Illinois, reviewers who conduct reviews of Physically Disabled waiver providers are Registered Nurses. This approach makes our findings more reliable and our recommendations evidence-based and authentic.

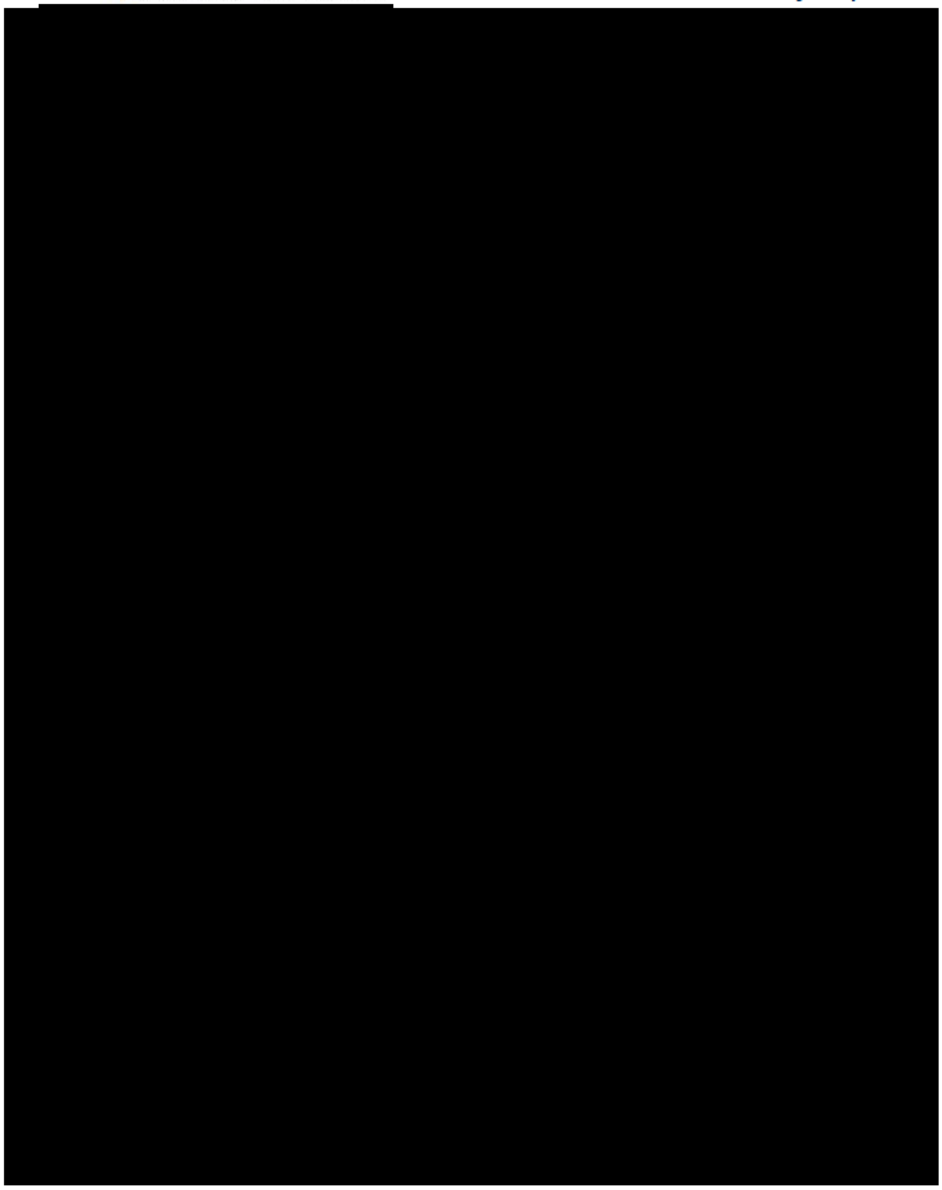
- ✓ **Streamlined Process for review**. Our clients expect our reviews to be reliable and sound, and providers expect our reviews to require a minimum of administrative burden through use of automated requests for information, ability to upload materials 24/7, and a Call Center for accurate, courteous assistance to make the process easier for provider staff. This approach makes our process more efficient, and helps to eliminate wasteful work for providers and Agency staff.
- ✓ **Informed and insightful findings and recommendations.** Our experience and expertise with HCBS delivery systems enables us to go beyond the surface of deficiencies to the root causes beneath performance issues – complex regulations, limited internal capacity, widespread locations, and staff turnover, for example. Our training and technical assistance interventions, proactive CAP monitoring, and development of tools and methods all help providers achieve our collective program goals. When we work together, we improve delivery of high quality services in the community for the Iowa residents who depend on them for safe and independent lives.

We first illustrate and discuss our overall approach to conducting provider reviews, based on IME procedures for periodic reviews. Our experience indicates that by developing core models for similar functions, it is easier for providers to understand the approach and participate successfully in the process.

In each section, we then address RFP items and discuss differences in the approach, materials used, roles and qualifications of staff who conduct the reviews; and other variations from our core methodology.

PROVIDER REVIEW IMPLEMENTATION

Figure 4.4-29 shows the model approach to implement provider reviews and request information. In preparation for Periodic and Focused Reviews, the provider population was divided into annual cohorts to receive review once every five years. We will maintain the annual schedule, and adjust it as indicated to defer providers who do not deliver services to members unless there are recent issues with performance.



We examined the procedures for HCBS provider reviews included in the RFP Library to develop standard and detailed procedures. Our proposed methodology to initiate reviews includes these eight (8) steps:

1) Select and review the annual cohort of HCBS providers for review. Providers will receive periodic and/or focused reviews on a five-year cycle, with a random sample selected for each fiscal year.

2) Determine provider review status.

a. Compile provider data by matching the sample to claims data to identify members receiving services. Assign provider to "no member" category if the provider does not currently deliver services to members.

Table 4.4-38. Overview of Set Up for Provider Review Process (Periodic Review).

An efficient approach to initiating provider reviews assures timely collection and management of documentation.

b. Research providers and assess risk. [See Research Providers section below.] Evaluate complaint and incident data to evaluate relevant performance issues; review any CAPS and provider responses and assess the relative risk level of the provider:

i. Low risk: No major incident reports; CAPs only for administrative deficiencies such as policies and procedures; no complaints from members.
ii. Moderate risk: No major incident reports; CAPs for non-administrative issues closed on a timely basis; member complaints investigated and resolved.
iii. High risk: Major incident reports and/or CAPS for non-administrative issues; CAPs not closed on a timely basis; member complaints investigated resulting in CAPS.

c. If the provider is "no member" and low risk, defer to next review cycle and replace with new provider to maintain sample size.

d. If the provider delivers services to members and is –

i. Low or moderate risk: conduct a desk review.
ii. High risk: conduct an onsite review. Assigned to regional HCBS Specialist with other team members depending on risk and provider size, locations.

3) **Consolidate Reviews.** If the provider is also in the annual cycle for focused reviews, or a targeted review is in process, consolidate activities and conduct a comprehensive review.

a. Combined Periodic/Focused Review: Conducted by HCBS Specialist.

b. Targeted Review for complaints/incidents: Conducted by HCBS Complaint and Incident Specialist with assistance from HCBS Specialist as needed for onsite components.

4) **Create QPS record for provider review**, and enter data to populate QPS Provider and Member Tabs.
5) **Manage documentation through OnBase**, and assign Document Control Numbers (DCN) to all documents and log DCNs in QPS.
6) **Issue model letter(s)** to provider to request materials for review and/or schedule an onsite review.
7) **Conduct email and telephonic follow-up** at days 5 and 10 with providers to ensure receipt of materials within 15 days.
8) **On receipt of materials and as scheduled, conduct desk or onsite review.**

RESEARCHING PROVIDERS

Using information to evaluate provider activity and risk improves the efficiency of the process and prepares the reviewer and/or team for the review process. An area we would investigate to determine the need for an onsite review is the prevalence of incidents reported by the provider. We propose to implement a supporting Dashboard system with data compiled from IME systems and consolidated for decision support. The system will flag provider records that match to factors that increase risk. Figure 4.4-30 shows the summary and charts for incidents by quarter, for example, with Law Enforcement incidents selected.

Table 4.4-39. Incident Reports by Type and Provider.

Using a data-driven approach to evaluating provider risk enables us to make informed decisions about the need for onsite provider reviews.

In this image, the HCBS Specialist views detailed provider information. By clicking on the provider ID of 329184, the bottom right view shows the provider name, a 12-month incident trend and all incidents for that provider for quarters 3 and 4. The table additionally shows 24-hour incident timeliness. We will also profile complaints and CAP activity in a similar format. HCBS Specialists can use this information to decide if an onsite review is required and if so, what information to request for the review.

PROVIDER REVIEW PROCESS DETAIL

When the implementation process is complete, system records and documentation are ready to initiate the review. We use a structured approach to review that is transparent and rigorous, to deliver results that enable us to provide effective oversight, administer corrective action plans that work; and improve

the quality of provider services. We show this process in 4.4-Table 4.4-40 and describe the 9 steps below:

1) Select Random Sample. Using the provider roster and staffing data, we finish setting up the review in QPS. We select records for three randomly selected members and an equal number of staff. We then request records from the providers.

2) The HCBS Specialist completes the Review Checklist in QPS (P11 form) and compares results to provider Self-Assessments. We propose component as a desk review for all providers, so that we can prepare questions and follow-up areas for the onsite process if conducted.

3) For desk reviews, we will request that the provider submit these records through IME secure systems, e.g., IMPA. Materials will include, for example:

   Provider licensure, ownership, and business location data.

   Policies and procedures for service delivery, documentation, complaints, incidents.

   Complaints and incident logs.

   Selected Member service records for 90 days/three months.

   Selected staff files.

   Training plan and summary of training delivered.

4) For onsite reviews, the HCBS Specialist will conduct an entrance interview, and review member records and provider files when onsite. Review of administrative materials occurs prior to the visit.

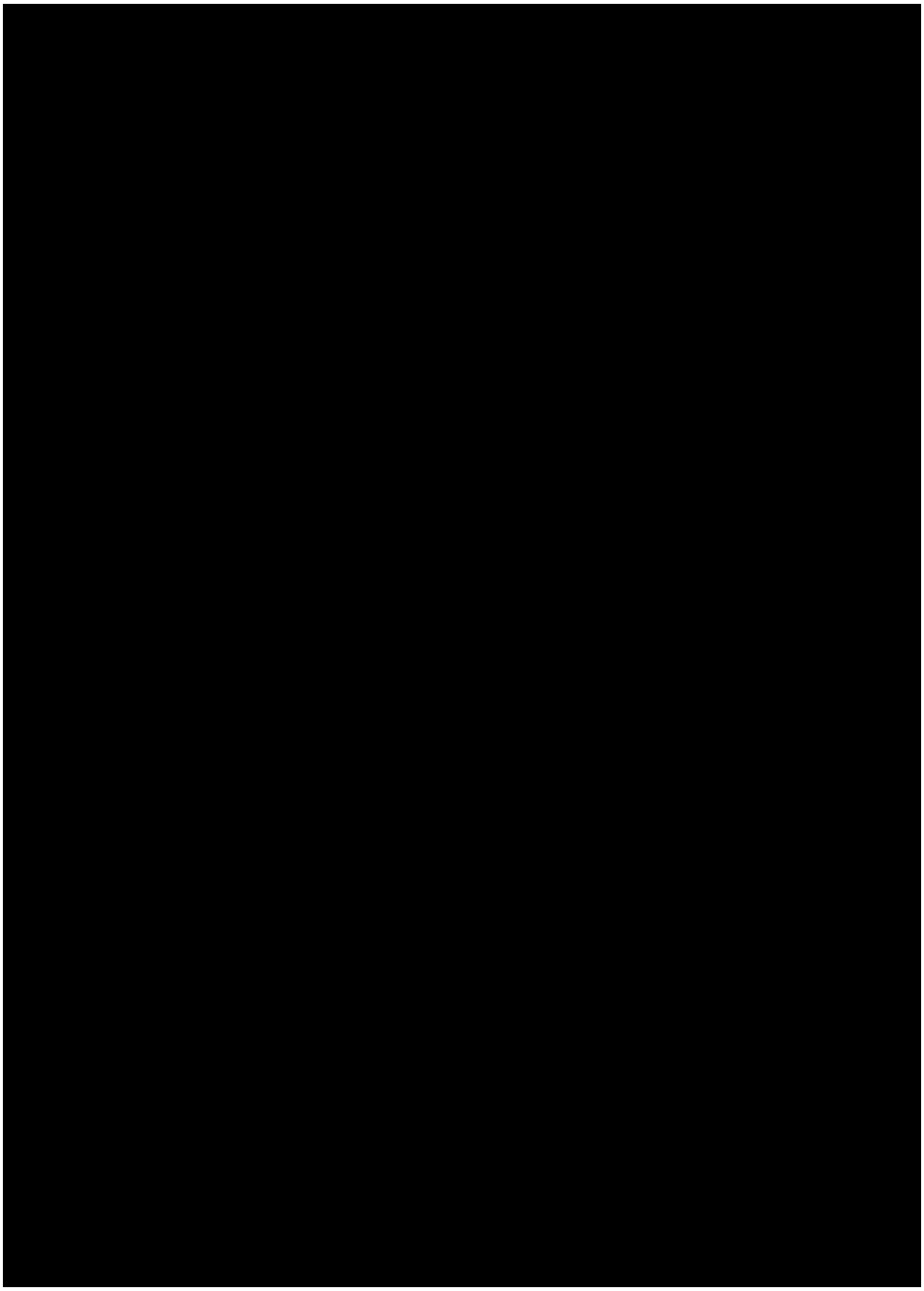
5) The HCBS Specialist will flag deficiencies in the materials as well as discrepancies between the Self-Assessment and the Review Checklist for follow-up with the provider.

6) When HCBS Specialists identify a threat to member health or safety, they will immediately notify the HCBS Operations Manager, who will take appropriate action.

7) HCBS Specialists complete the Review Report (P14) after discussing missing materials or other concerns with providers. If results indicate the need for a CAP, the Specialist and HCBS Operations Manager will review the report. After Manager review and approval, we will request a CAP.

8) Providers may request negotiation, and we will work with providers to ensure an equitable determination. We will then finalize the review determination and complete documentation in QPS.

9) CAP monitoring continues until the provider addresses all issues, and we prepare monthly, quarterly, and annual reports as we describe in Section 4.4.1.



During transition, we will review our proposed core methodology with the Agency, and submit policies and procedures, notifications, and reporting format for review and approval. We will then maintain these materials by reviewing them on at least an annual basis, and updating to reflect changes in requirements, regulations, and best practice.

1. The Contractor shall conduct the following types of reviews for HCBS waiver and Habilitation programs:
a. Periodic Reviews. Duties include but are not limited to:
j. 100% of enrolled providers are reviewed onsite over a randomized five-year cycle. Periodic reviews may be completed in a combination of desk review or onsite visits, depending on the level of provider intervention required.
ii. Reviews shall always include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.
iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
iii. Periodic review tool(s) shall be approved by the Agency on an annual basis.

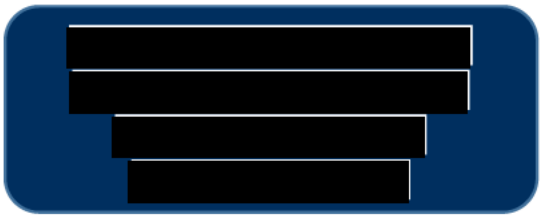
Table 4.4-40. Provider Review Process.

We complete over 1,500 provider reviews each year for quality oversight and CMS HCBS Reporting.

Periodic reviews evaluate the compliance and performance status of providers that deliver services to HCBS waiver, habilitation, and MFP providers. We understand that the randomized annual cohorts for periodic reviews were established during the prior contract. We will assume responsibility to maintain the selection, and review it on an annual basis with the Agency to ensure that all providers receive a periodic review on a five-year cycle (4.4.2.1.a.i). Criteria we use to determine whether a review will be desk or onsite includes, for example:

1. Results of previous certification, periodic, focused, or targeted reviews. If an onsite review was conducted during the prior contract, we will evaluate if findings suggest desk review is appropriate.
2. Findings from the most recent review of the provider's self-assessment. If the provider submitted an assessment with errors and required multiple attempts to correct the data, for example, it will be more helpful to the provider to conduct a site review.
3. Type, frequency, and status of complaints and incidents. Providers with low volumes of successfully resolved complaints and low volumes of major incidents might require only a desk review to evaluate performance adequately.
4. Type of provider. For providers that deliver residential services, an onsite review is a best practice if one did not occur in the past 1-2 years and/or the provider is new, has recently expanded, or has multiple operational sites. We will consider this factor as one element in determining that an onsite review is appropriate.
5. Need for follow-up to previous reviews. We understand that policies and procedures were the area with the most frequent deficiencies. In our experience, many providers underestimate the level of effort required to develop and maintain appropriate policies and procedures. Since they provide the basis of compliant operations, it is important that they be accurate, current, and communicated to staff members. We will consider follow-up needs after previous corrective actions as an element in deciding to conduct onsite or desk review.

We balance these considerations with respect for the administrative burden that review places on home and community-based providers. Our reviews generate objective and informed findings that providers can use to improve performance, as well as meet Iowa standards and qualify for desk review in future cycles.



The materials we use to conduct reviews include standard documentation of the provider organization and operations (4.4.2.1.a.ii). We request and evaluate provider:

1) Organizational data such as:
   a. Ownership and Governance Information. We examine these materials to determine potential conflicts of interest; independence and role of the Board (e.g., are members represented?); and process to report critical information such as complaints and incidents.
   b. Certification Status. Is the provider within the initial 270 days of the initial certification review? Did this review identify any issues requiring follow-up?
   c. Licensure Status. Is the provider licensed and in good standing with the State of Iowa as a business entity?

2) Operational data such as:

   a. Self-assessment (4.2.a.iii). Did the last self-assessment review indicate the need for follow-up? Does the provider's self-assessment align with its implementation of policies and procedures as demonstrated by review of those materials? Were there issues with the self-assessment that were difficult for the provider to resolve? Does the provider require technical assistance with the self-assessment?
   b. Policies and Procedures. How does the provider document methods and requirements for service delivery? What procedures enforce reporting of complaints and incidents?
   c. Training Records. How does the provider prepare individuals to deliver services to members? Does the provider evaluate training and use data for improvement? How often does the provider conduct training?
   d. Employment Records. Are staff files complete and organized? Are licenses documented and up to date?

3) Financial data such as:

   a. Most recent audited income and expense statement.
   b. Accounts receivable and billing management.
   c. Accounts payable and financial management.
   d. Claims oversight and management.

4) Service delivery data such as:

   a. Member Records. How well does the provider maintain member records according to industry documentation standards? Do member records support claims and billing information? Is the member's service delivery consistent with the care plan? Are there records that accurately document delivery of services to members?
   b. Complaints and incident reports. Were there complaints from members? Were incidents reported timely? How were incidents and complaints resolved?
   c. Member Experience. Does the provider collect, review, and/or use reports of member experience to improve services?
   d. Quality measurement and improvement. Does the provider have a quality assurance and improvement (QA/QI) program?

Our clients rely on our accurate, complete, and timely data to meet CMS requirements for assurances and sub-assurances, as well as any special terms and conditions of the waiver. For example, we will evaluate the interactions of MCOs and HCBS providers, and report on implications for technical assistance and training for MCOs and providers to ensure access to quality HCBS services to members in both FFS and managed care populations. Tools that we use to conduct will receive review and approval from the Agency in advance (4.4.2.1.a.iv). The HCBS Operations Manager will be responsible for revision of existing tools for use with Iowa's HCBS program, incorporating our models with current versions. The Manager will also submit the instrument(s) to the Agency for review and approval, allowing at least 15 days for that process. After review, we will update and finalize the instrument. We include examples of review tools for periodic review (Illinois HCBS Waivers) and for residential and non-residential HCBW providers (West Virginia ASO) in Exhibit 2. As these instruments demonstrate, we align our review activities with state and federal requirements to ensure we collect data for contract reporting as well as HCBS Quality Assurances to CMS.

b. Focused Desk Reviews. Duties include but are not limited to:

i. *100% of enrolled providers are reviewed onsite over a randomized five year cycle. Focused reviews may be completed in a combination of desk review or onsite visits, depending on the level of provider intervention required.*
ii. *Areas of focus are determined by the Agency, based on CMS quality framework, HCBS settings requirements, and other trends.*
iii. *Reviews may include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.*
iv. *Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.*
v. *Focused review tool(s) shall be approved by the Agency on an annual basis.*
vi. *Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.*

This review component addresses provider performance in a similar fashion to periodic reviews, but instead addresses specific topics selected by the Agency on an annual basis. The focus for state fiscal year 2017, for example, was on federal rules for HCBS settings. Provider cohorts for annual review are also randomly selected on a 5-year cycle to such that 100% of providers participate in a focused review (4.4.2.1.b.i). We will maintain these cohorts and review them each year with the Agency. For example, if we defer a provider because it does not deliver services to members when the focused review occurs, we will move it to another cohort for review during a later cycle. We will apply the same criteria that we describe in Section 4.4.2.1.a. to determine if will conduct a desk or onsite review. In addition to those considerations, we will also take into account the specific topic. It could be the case, such as with a safety topic, that it is not possible to conduct the review without visiting the site.

Note: Depending on the topic, we recommend that focused reviews be completed within one-two quarters. A compressed timeframe for completion makes available results of the reviews more quickly so the Agency can apply recommendations for improvement. We also suggest that providers may participate in focused reviews more than once every five years depending on how relevant the topic is to their organizations.

The Agency will determine the area of focus, and will be able to use information we collect and report from all our activities (4.4.2.1.b.ii). Topics could include areas such as best practices for policies and procedures; creating person-centered care plans; or timely reporting of incidents [according to the Revised HCBS SFY17 Quarterly Report, there were 834 incidents, with 56% reported untimely]. If the Agency requires additional information to use in selecting a topic, our data analysts and policy experts are available to create ad hoc reports and provide consultation at the Agency's convenience. For example, as the Beneficiary and Family Centered QIO for 34 states including Iowa, we are responsible to promote patient and family-engaged care across settings and providers. With expert teams for quality oversight of HCBS settings and services, Medicare-reimbursed care, and the Military Health System worldwide, we have resources the Agency can access to discuss focused reviews of services to Iowa members.

We will request and review materials as we discuss in 4.4.2.1.a, and may limit our request for information to materials related to the topic under review rather than all provider documentation, depending on the topic (4.4.2.1.b.iii). In requesting information, we will first access materials already submitted for other reviews and/or requirements, such as periodic reviews, targeted reviews, incident reviews, etc. We will consolidate materials and only request information we need but do not have. This approach helps to make our approach more efficient and reduces the level of effort and time required for providers to submit documentation. As part of each focused review, we will access the provider's self-assessment and previous reviews of this document (4.4.2.1.b.iv). That process establishes the provider's own evaluation of its compliance with state and federal requirements and helps us identify gaps in implementation that require further investigation. If we already reviewed the self-assessment as part of another function, we will incorporate those findings into our focused review process.

The local Iowa team will prepare or update an instrument for review and approval by the Agency (4.4.2.1.b.v) on an annual basis. We suggest developing an instrument for each focused review to ensure information we collect is specific to the topic and meets focused review reporting needs of the Agency. The HCBS Operations Manager will be responsible for oversight of instrument development and submission to the Agency for review and approval. We will provide at least 15 days for this process, and after review by the Agency, we will incorporate comments and recommendations and finalize the tool.

Since the topic will change on an annual basis, we will train reviewers on specifics prior to implementing the process. This approach ensures they understand the purpose of the review; any considerations such as relevant regulations or CMS rules; and how to collect the required data elements from provider materials. Our quality assurance will validate the reliability and accuracy of reviews through the following process:

1) Inter-rater reliability determination using gold standard cases to assess reviewer performance. Each HCBS Specialist who will participate in the Focused Review will complete a review of gold standard cases. We create these cases with pre-determined elements to collect and review findings. Specialists who score lower than 85% will receive retraining and testing until proficient.

2) Re-review by supervisors. The HCBS management team will include licensed clinicians with relevant credentials for HCBS services. Clinicians will re-review the first five (5) cases and score the results of this "super-rater" review. Specialists who receive a score lower than 85% will receive retraining and retesting on elements that contributed to their score.

3) For onsite reviews, managers will accompany Specialists on one or more site visits and observe their performance. We will provide feedback and retraining as needed.

The HCBS team will compile the results of these internal quality assurance activities and report them to the Agency on a monthly, quarterly, and annual basis (4.4.2.1.b.vi) as follows:

- Monthly Report. The monthly report will include the volume of focused reviews completed during the month; the number of cases reviewed by Specialist; the type of quality assurance completed, and the results of the evaluations.
- Quarterly Report. On a quarterly basis, we will compile quality assurance results from the previous three months and evaluate any patterns we detect in scores. We will also make recommendations for improving our training and testing processes for future focused reviews.
- Annual Report. The annual report will include an assessment of the focused review for the period, including Specialist reliability, timeliness, suggestions to improve forms, etc.

The HCBS Operations Manager will submit the reports to the Agency for review and approval, and finalize the reports based on Agency comments and suggestions.

c. Targeted Reviews. Duties include but are not limited to:

i. Review shall be initiated as a result of concerns arising from a desk review, complaint, incident, or Agency referral.

ii. Reviews shall include investigation of the targeted issue or concern. Areas of reviews may include, but are not limited to, review of member documentation, policies and procedures, employee records, incident reports, member survey and financial statements.

iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.

iv. Conduct provider targeted reviews as desk reviews unless circumstances rise to level that requires an onsite review.

v. The Contractor shall provide technical assistance and training to providers to demonstrate increased provider compliance of targeted review areas, to include but not limited to:

a) Analyze and trend areas of deficiency in MCO and FFS each quarter and provide appropriate aggregate outreach to providers on a quarterly or annual basis.

b) Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.

c) Report findings to the Agency on a quarterly and annual basis.

vi. Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.

HCBS Specialists and the HCBS Complaint and Incident Specialist will identify the need for a targeted review based on concerns we identify through other contract responsibilities, including desk reviews, complaints, incidents, or self-assessment review. The Agency will also make referrals for targeted reviews (4.4.2.1.c.i). The HCBS Operations Manager will approve a targeted review, and will notify the Agency in the event of targeted reviews of issues involving member health and/or safety.

The Operations Manager will assign the HCBS Specialist for the regional provider location. If the targeted review results from complaints and/or incidents, the HCBS Complaint and Incident Specialist will lead the review, with collaboration from the regional HCBS Specialist.

Since targeted reviews result from concerns, it is important to implement the review efficiently. For this reason, we will use the standard instrument we develop for periodic review, and revise it to collect additional information on the issue if needed. We propose to conduct targeted reviews in two phases:

1) Desk Review. The HCBS Specialist will request any additional information needed for the review and include it with materials already compiled for the provider. This information will include at a minimum the self-assessment; policies and procedures relevant to the concern; personnel files; financial records, etc. (4.4.2.1.c.ii). If we did not already validate the provider self-assessment through other activities, the HCBS Specialist will complete review the assessment and other materials, documenting areas where implementation was not consistent with the self-attestations (4.4.2.1.c.iii). Other information may include complaint and incident files as relevant. HCBS Specialists will examine these materials, document their findings, and prepare the report. If we cannot complete the review as a desk review, we will initiate phase two and conduct a site review (4.4.2.1.c.iv). The Complaint and Incident Specialist will conduct the desk review of all cases involving relevant issues, and collaborate with regional HCBS Specialists on the site review.

2) Site Reviews. HCBS Specialists who conduct the desk review will prepare a set of questions/items for the site review to address unanswered areas of concern and/or areas requiring validation. This approach makes the site visit more efficient as well as ensuring that the concerns addressed in desk review have consistent follow-up and resolution. The HCBS Specialist will schedule the site visit in advance, conduct an entrance meeting, and complete the site portion of the review. The Specialist will also conduct an exit interview.

Note: we also have experience with conducting unannounced site visits should the circumstances indicate.

After we complete the review and confirm our findings, we will provide training and technical assistance to address areas of deficiency to improve documentation, compliance, and quality (4.4.2.1.c.v). Using current data from MCOs and the FFS reviews as well as results from the last contract, we will analyze these areas to formulate interventions. For example, health and safety concerns and non-compliance with IAC were the two most prevalent areas for targeted reviews. Our technical assistance in these areas includes:

- How to identify and address health and safety risks in HCBS settings, including risk of falls, medication adherence, etc. With our extensive library of training from the SW Pennsylvania HCQU, we have extensive resources available for this purpose.
- Services available in specific waivers to address health and safety concerns, such as PERS, home modifications, and respite.
- Checklists and quick references for IAC, including assisting providers with updating their policies and procedures, training staff, and updating manuals. For example, we will develop training presentations providers can download from the HCBS Website and use for staff training on areas of IAC and waiver rules.

We will provide detailed reports on targeted review and interventions in our quarterly and annual reports, including information such as:

- Results of data analysis and recommendations for targeted review.
- Breakout of results by MCO and FFS.
- Volume of targeted reviews by topic.
- Deficiencies and technical assistance.
- Recommendations for further action.

Using the same methods, we propose in our response to 4.2.1.b, we will conduct quality assurance of our processes to the extent the volume of review supports, and will report to the Agency on a monthly, quarterly, and annual basis (4.4.2.1.c.vi).

4.4.3 CERTIFICATION REVIEWS OF ENROLLED PROVIDERS. DUTIES INCLUDE BUT ARE NOT LIMITED TO:

i. Certification reviews shall be conducted within the program mandated timeframe found in Iowa Admin. Code ch. 441-77.
ii. Reviews include, but are not limited to, policies and procedures, staff training, and employee records.
iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
iv. Develop certification tool(s) and review on an annual basis.
v. Submit certification tool(s) to the Agency for approval on an annual basis.
vi. The Contractor shall provide technical assistance and training to providers to demonstrate increased provider compliance on certification onsite reviews to include but not limited to:
a) Analyze and trend areas of deficiency each quarter and provide appropriate aggregate outreach to providers on a quarterly or annual basis;
b) Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice; and
c) Report findings to the Agency on a quarterly and annual basis.
vii. Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.

IAC 441-77 requires completion of certification review within 60 days of receipt of the provider application (4.4.2.1.d.i). We will complete certifications reviews as a desk review process following our overall process as shown in Table 4.4-38 and Table 4.4-40, including major steps in the process:

1) Log in receipt of application at HCBS Unit. The timing of review starts with this date.
2) An HCBS Specialist will review the application to identify any missing documentation that substantiates the provider's readiness to deliver HCBS services. We will review (4.4.2.1.d.ii):
    a. Provider self-assessment and validate compliance through implementation of appropriate policies, procedures, and operational controls (4.4.2.1.d.iii).
    b. Operational policies and procedures, with an emphasis on timely submission of incident reports.

c. Employment records, including relevant licensure.
d. Staff training materials and records.
e. Governance and quality control plan.

3) Support staff will request additional information as needed for the certification review.

4) Our determination will reference criteria in 441-77 such as:

a. Complete and compliant application with substantiating documentation.
b. Status of the provider's financial ability to deliver services as proposed.
c. Documentation of service design and coordination with relevant entities including other medical and HCBS providers.
d. Written agreement to comply with IAC and federal regulations applicable to service delivery.

Note: We will evaluate the current certification review instrument and propose modifications during transition only if needed. The rationale for this approach is to prevent confusion on versions for providers that have certifications or re-certifications in process or are following up on corrective actions from certification review. It also minimizes the need for HCBS Specialists to administer different tools for different providers at various stages of the process.

We will then implement an annual schedule of review and approval to address issues in the certification instrument, such as changes in IAC or federal regulations, areas requiring clarifications, and items that can be eliminated **(4.4.2.1.d.iv-v).** The HCBS Operations Manager and Specialists will compile recommendations for changes to this instrument as well as others we use for HCBS review functions, and the Manager will submit our revised tools to the Agency for review and approval at least 60 days in advance of proposed implementation.

This process also enables us to publish changes to tools **at least 30 days in advance** of requiring their use by providers or using them for provider reviews. In addition to publishing instruments in advance, we will also develop training tools (in conjunction with the MCOs as relevant) and publish them to prepare provider staff for implementation.

5) Member choice requires access to certified providers in every region. Our certification review should therefore build provider capacity for successful delivery of services to members in both FFS and managed care delivery systems. During the certification review process, we will collaborate with providers to help them meet certification standards, as well as understand differences in requirements for FFS and managed care, such as prior authorization requirements, documentation standards, and billing processes (4.4.2.1.d.vi-a-c). These activities will include:

a. Contact with providers and discussion of our findings, with recommendations for improvement to documentation standards, policies and procedures, or staff training for example.
b. We will record all our activities for further analysis, and include them in reports. This aspect of all our reviews enables us to accurately describe and validate our activities as well as replicate our findings for quality assurance.
c. The Data Analyst will summarize activities on a quarterly and annual basis for reporting to the Agency. The HCBS Operations Manager and Specialists will review the results and evaluate them for patterns and trends, such as common deficiencies, issues with

documentation, and discrepancies between the self-assessment and certification materials.

Certification review results in the following outcomes:

1) Initial certification for 270 calendar days from the date of determination.
2) Recertification after onsite review (with exceptions for independently certified providers). Recertification is for specific timeframes and requirements based on achievement of the 20 processes identified in sub-rules 77.37(1) and 77.37(2), depending on type of provider.
    a. Three-year certification with excellence (18 or more processes and outcomes/processes of 12 or higher).
    b. Three-year certification with follow-up monitoring (17 or more processes and 11 or more outcomes/processes).
    c. One-year certification (14 or more processes and 9 or more outcomes/processes) OR outstanding CAPs.
    d. Probational Certification. Issued for an additional 270 days when providers cannot meet requirements for a one-year certification. This status requires follow-up onsite review to complete certification.

Our internal quality assurance (QA) will include these activities:

- Random sample of certification reviews for each HCBS Specialist.
- Evaluation by the HCBS Operations Manager or other senior staff member to validate compliance with certification review requirements.
- Concurrence with outcome of review (e.g., certification and recertification timeframes).

The quality assurance reviewer will document the results including:

- Compliance.
- Completion.
- Timeliness.
- Accuracy.
- Outcomes.

We will then report on quality assurance results on a monthly, quarterly, and annual basis (4.4.2.1.d.vi). Monthly reports will summarize QA activities by HCBS Specialist, with the requirement that Specialists achieve a minimum of 95% on all categories. We will also include major findings, such as the need for changes to the process, training, or tool. Our quarterly and annual reports will compile our results and identify patterns and trends in certification review compliance, and our recommendations for improvement.

4.4.4 CHAPTER 24/HCBS WAIVER PROVIDER ONSITE REVIEWS.

The Contractor shall collaborate with the Agency's Division of Mental Health and Disability Services (MHDS) to provide quality oversight of providers of Iowa Admin. Code ch. 441-24 services, also known as Chapter 24 providers, and HCBS waiver services. The Contractor shall manage, monitor, and follow-up on collaborative on-site reviews to include but not limited to:

i. Conduct Chapter 24/HCBS reviews:
    a) Upon request, enrolled Chapter 24/HCBS waiver providers are reviewed onsite within the program mandated timeframe.
    b) Reviews shall always include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.
    c) Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
    d) Periodic review tool(s) shall be approved by the Agency on an annual basis.

e) *Report totals of Chapter 24/HCBS reviews on a monthly, quarterly, and annual basis.*

ii. *Provide technical assistance and training to providers to demonstrate increased provider compliance on Chapter 24/HCBS onsite reviews to include but not limited to:*
   a) *Analyze and trend areas of deficiency and provide appropriate aggregate outreach to providers on a quarterly and annual basis.*
   b) *Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.*
   c) *Report findings to the Agency on a quarterly and annual basis.*

iii. *Collaborate with the MHDS to include but not limited to:*
   a) *Attend meetings to discuss progress on reviews.*
   b) *Coordinate scheduled reviews.*
   c) *Discuss and collaborate on all rule revisions and implementation that are necessary.*
   d) *Report activities to the Agency on a quarterly and annual basis.*

[redacted]

Figure 4.4-12. Review of Chapter 24/HCBS Providers

Our proven review methodology will result in accurate and timely findings and recommendations MHSD and IME can use for program management.

[redacted]

4.4.5 PROVIDER SELF-ASSESSMENT REVIEWS.

The Contractor shall review completed provider annual self-assessments to ensure full completion and compliance to include but not limited to:

i. *Ensure that providers are complying with quality self-assessment requirements defined in State and Federal laws, rules, and regulations as well as industry accepted standards for best practice.*
ii. *Review and revise self-assessment tool(s) on an annual basis and attain approval by the Agency.*
iii. *Publish the self-assessment tool, as approved by the Agency, and a publicly communicate a deadline for submission on the HCBS website.*
iv. *Ensure that 100% of enrolled providers submit an annual self-assessment.*
v. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

[redacted]

Table 4.4-41. Benefits of our Approach to Provider Self-Assessments.

Automating completion of the self-assessment improves compliance and reduces provider burden.

[redacted]

2. *Unless otherwise specified in the section above, the Contractor shall collaborate with the Agency's Managed Care Organizations (MCOs) to provide technical assistance and training to providers to demonstrate increased provider compliance on reviews to include but not limited to:*
   a. *Analyze and trend areas of deficiencies and provide appropriate aggregate outreach to providers on a quarterly basis.*
   d. *Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.*
   e. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

MANAGED CARE ORGANIZATIONS TECHNICAL ASSISTANCE

[redacted]

Table 4.4-42. After reviewing current IME, here is what we found:

KEPRO FINDINGS: Analysis of [redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted] following up with

[redacted]

[redacted]

Table 4.4-43. Reporting in Details on Barriers to Quality in HCBS Services

[redacted]

3. The Contractor shall submit all reports of provider reviews to include but not limited to:

a. Findings report shall articulate when deficiencies are found and relevant correlations to State and Federal rule, law, and regulation as well as industry accepted standards for best practice.

b. Report findings to the Agency on a monthly, quarterly, and annual basis, in an Agency-approved format.

PROVIDER REVIEW REPORTS

[redacted]

[redacted]

4. *The Contractor shall initiate development of corrective action plans (CAPs) with providers who have policy, procedure, and outcome deficiencies based off reviews, to include but not limited to:*
   a. *CAP initiation shall occur simultaneously with review findings report.*
   b. *Provide education and assistance when areas of compliance are not clearly established such that the provider can attain a plan for achievable success within the timeframe preceding the follow-up compliance review.*
   c. *Review and approve CAPs to come into compliance with IAC standards at a 100% level.*
   d. *The review and approval process shall be based on established protocols approved by the Agency.*
   e. *Subsequent correspondence with providers shall be in a format approved by the Agency.*
   f. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

[redacted]

[redacted]

1. [redacted]

Figure 4.4-13. Overview of CAP Process

We manage a transparent CAP process to ensure provider remediation.

[redacted]

[redacted]

5. *The Contractor shall conduct a follow up compliance review to ensure that the provider has implemented policies and procedures agreed upon in the approved CAP, and report findings to the Agency on a monthly, quarterly, and annual basis.*

[redacted]

HCBS WAIVER, HABILITATION, AND MFP PROVIDER COMPLAINTS (C.)

C. HCBS Waiver, Habilitation, and MFP Provider Complaints

This Section applies to the FFS population, except where MCO reporting indicates there are providers with similar complaints open with multiple MCOs. If there is a systemic issue with a provider, the Contractor shall request more information from the provider and follow-up as described below.

1. *The Contractor shall handle complaints in a manner consistent with the Agency to include but not limited to:*
   a. *Ensure complaints have an initial assessment completed within three (3) business days and the resulting action(s) will be in accordance with HCBS waiver, Habilitation, and MFP program policies, procedures and State and Federal rules, laws, and regulations.*
   b. *Resulting action (e.g. investigation, closure, or referral) shall be logged and reported to the Agency.*
   c. *Initiate fact-finding correspondence with relevant parties and correspondence within two business days of initial assessment.*
   d. *Correspondence with all parties shall be in a format approved by the Agency.*
   e. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

[redacted]

[redacted]

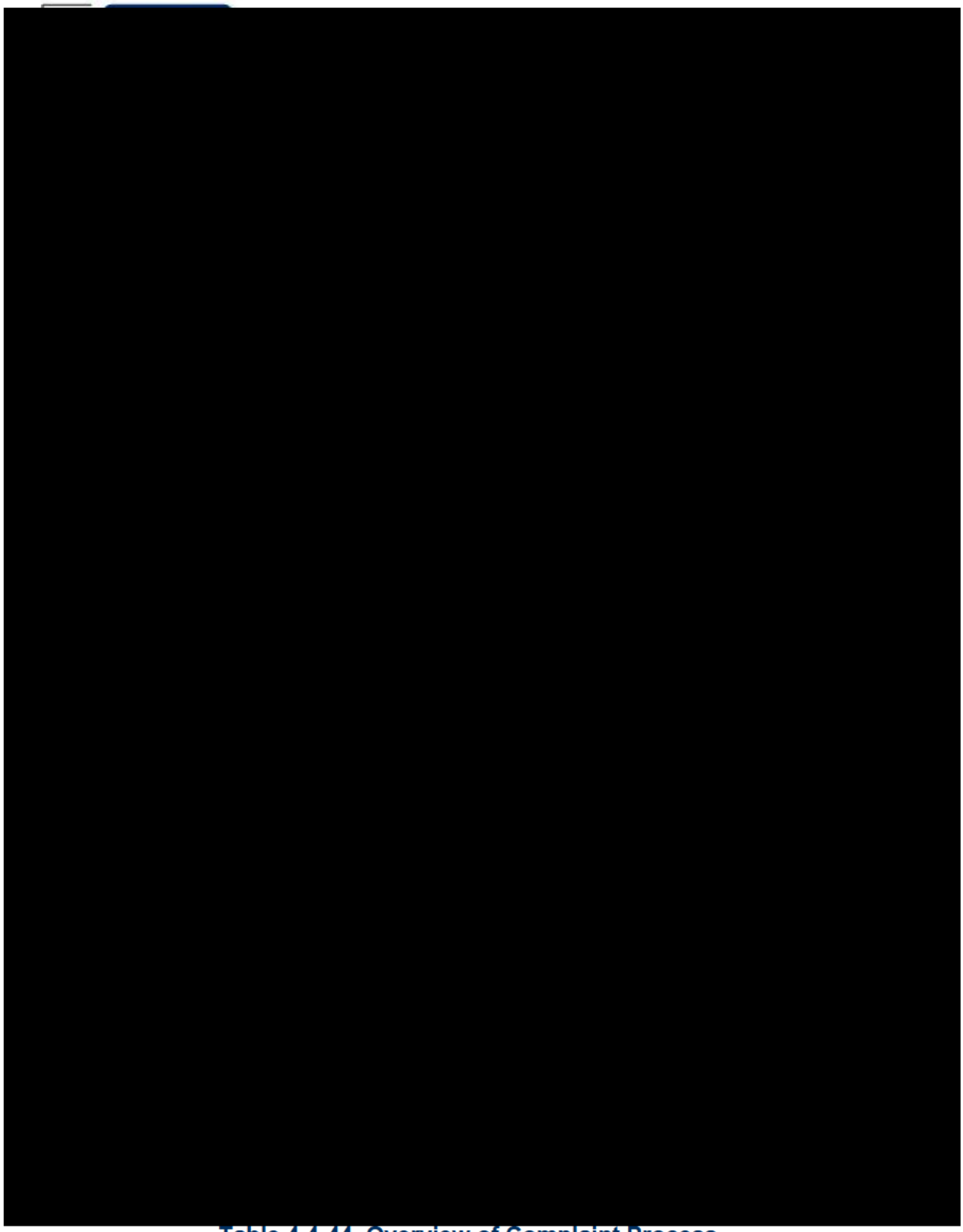


Table 4.4-44. Overview of Complaint Process.

Responding efficiently to sources of complaints ensures member concerns receive appropriate and timely resolution.

2. *The Contractor shall conduct investigations of complaints when determined necessary in initial assessment to include but not limited to:*
   a. *Notify the Agency and the applicable provider if it is determined during the initial assessment that an investigation is necessary.*
   b. *Correspondence with the provider shall be in a format approved by the Agency.*
   c. *Correspondence and associated data shall be logged within an electronic database.*
   d. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

[redacted]

[redacted]

COMPLAINT MANAGEMENT

3. *The Contractor shall make written recommendations to the Agency related to complaint management to include but not limited to:*
   a. *Recommendations identify system improvements and best practices in complaint management.*
   b. *Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.*
   c. *Report recommendations to the Agency on a quarterly and annual basis.*

[redacted]

4.4.6 HCBS WAIVER, HABILITATION, AND MFP PROVIDER INCIDENT REPORT MANAGEMENT (D.)

D. *HCBS Waiver, Habilitation, and MFP Provider Incident Reporting Management*
   1. *This Section applies to the FFS population, except where MCO reporting indicates there are providers with similar incidents open with multiple MCOs. If there is a systemic issue with a provider, the Contractor shall request more information from the provider and follow-up as described below.*

INTRODUCTION OF INCIDENT REPORT MANAGEMENT

[redacted]

Table 4.4-45. HCBS Waivers – Major and Minor Incidents

Iowa Administrative Code defines major and minor incidents for reporting to the Agency

[redacted]

OVERVIEW OF PROCESS

1. *The Contractor shall ensure that HCBS waiver, Habilitation and MFP providers are complying with incident reporting requirements to include but not limited to:*
   a. *Provide education and assistance when it is discovered that providers are not adhering or are misinterpreting requirements or industry accepted standards for best practice.*
   b. *Identify trend areas of deficiency each quarter and provide training or outreach to clarify requirements.*
   c. *Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.*

d. Report findings to the Agency on a quarterly and annual basis.

Figure 4.4-14. Overview of Incident Management.

We developed our process through 10 years of HCBS management for efficient discovery and remediation of incidents

[redacted]

[redacted]

EXAMPLE REPORT: CUMULATIVE INCIDENT REPORT- SFY QUARTER 4

[redacted]

Table 4.4-46. After reviewing current IME, here is what we found:

KEPRO ACTIONABLE RECOMMENDATIONS

[redacted]

Table 4.4-47. SFY Incident Reports by Type of Report

Total figures per quarter represent incidents reported in that quarter, with the percent calculated as the rate of incidents over quarterly totals.

[redacted]											
[redacted]											
[redacted]											
[redacted]											
[redacted]											
[redacted]											

[redacted]

[redacted]

These two types of incident represent 64% - 80% of all reported events for the annual period, representing a pattern of results that requires further investigation.

[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							
[redacted]							

[redacted]

Table 4.4-49. Cumulative Volume of Incidents by Type and Quarter.

Incident Reports for Law Enforcement Interventions and Physical Injuries have the highest quarterly prevalence.

[redacted]

[redacted]

Table 4.4-50. Law Enforcement Interventions as a Percent of Totals.

Increases in Law Enforcement Interventions Drive Increase in Quarterly Totals

6. *The Contractor shall ensure that providers are submitting incident reports into the Iowa Medicaid Portal Access (IMPA) system on a timely basis to include but not limited to:*
   a. *For incidents that are faxed/mailed to the Agency, the Contractor shall follow up with provider to remind them of the IMPA requirement.*
   b. *Provide training or outreach to providers who are not submitting incident reports within the mandated timeframe.*
   c. *Initiate contact with the provider to remediate the rate of untimely submission upon discovery of provider submitting incidents in IMPA outside the mandated timeframe.*
   d. *Report findings to the Agency on a quarterly and annual basis.*

[redacted]

[redacted]

Table 4.4-51. Iowa Administrative Code References.

The HCBS Team will use IAC to ensure accurate management.

[redacted]

FOLLOW UP FOR INCIDENT REPORTS (4.4.4.2.a)

[redacted]

Figure 4.4-15. Multiple Sources to Identify Incidents for Reporting.

The HCBS team will actively work with the community to ensure we receive all incident reports for review.

[redacted]

7. *The Contractor shall complete targeted reviews of providers based on incident reports to include but not limited to:*
   a. *Health and welfare of an individual or individuals appears to be at risk, either presently or in the future.*
   b. *Immediately notify the Agency and the case manager or service worker.*
   c. *Notify the provider in advance of the review unless it is determined that the individual is in immediate jeopardy.*
   d. *Associated correspondence shall be in a format approved by the Agency.*
   e. *Report findings to the Agency on a monthly, quarterly, and annual basis.*

REPORTING ISSUES (4.4.4.3.a)

[redacted]

NOTICE TO THE AGENCY (4.4.4.3.b)

[redacted]

The HCBS Specialist will document the date and time of our notice to the Agency, and we will also retain the Dashboard report so that we can reference it in the future if required.

NOTICE TO PROVIDERS (4.4.4.3.c)

[redacted]

FORMAT FOR CORRESPONDENCE (4.4.4.3.d)

[redacted]

TO THE AGENCY (4.4.4.3.e)

[redacted]

Table 4.4-52. Structure and Content of the Targeted Review Report

Our post visit report ensures the Agency has timely and complete information on the results of targeted reviews and can take appropriate action to assure member health and safety.

[redacted]

8. *The Contractor shall meet with the Agency staff to review the previous period's major incidents to include but not limited to:*
   a. *Report the discovery, remediation and improvement activities for flagged incident reports.*
   b. *Provide monthly, quarterly and annual reports with statistical analysis and trending of aggregate incident data as well as detailed information on the discovery and remediation associated with flagged incident reports.*
   c. *Provide evaluate a statistically valid sample at a 95% confidence level to identify error rate of data entry for provider submitted reports.*
   d. *Report findings to the Agency on a monthly, quarterly, and annual basis, in an Agency-approved format.*

MEETINGS WITH THE AGENCY (4.4.4.4.a)

[redacted]

REPORTING TO THE AGENCY (4.4.4.4.b)

[redacted]

ERROR RATE CALCULATION (4.4.4.4.c)

The purpose of this activity is to provide a measure of the errors in incident reports that we can use to [redacted]

Table 4.4-53. Example of Sample Selections

Breaking the universe into small segments increases sample size at the 95% confidence level/5% error.

[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			

[redacted]

[redacted]

REPORTING FINDINGS (4.4.4.4.d)

[redacted]

9. The Contractor shall make written recommendations to the Agency related to incident reporting to include but not limited to:

a. Recommendations identify improvements and best practices in incident report management.
b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.
c. Report recommendations to the Agency on a quarterly and annual basis.

RECOMMENDATIONS FOR INCIDENT REPORTING (4.4.4.5 a-c)

[redacted]

4.4.7 HCBS WAIVER AND HABILITATION MEMBER SURVEYS (E.)

E. HCBS Waiver and Habilitation Member Surveys
This section applies only to the FFS population.

Home and community-based and habilitation services make it possible for individuals to avoid institutionalization and remain safely in community settings. They help individuals gain and retain physical, social, and role functioning, leading to improved quality of life and the ability to be part of society. For these reasons, it is important to understand and evaluate the extent to which the services meet the needs of individuals and help them achieve their goals. Participant Experience Surveys serve that purpose and are an established part of HCBS programs.

During the Transition period, our HCBS experts will review these documents and discuss potential improvements in the documents and process with the Agency.

FINDINGS: For example, we analyzed readability statistics for the Member notice letter included in the Bidder's Library (Home and Community Based Services (HCBS) Quality Oversight – Iowa Participant Experience Survey (IPES) Process). Microsoft Word scored the document as follows:

- Passive Voice Sentences: 13%
- Flesch/Kincaid Readability Score: 64
- Grade Level: 9

ACTIONABLE RECOMMENDATIONS: We modified the letter and show it below. This version assures individuals upfront that their participation is voluntary and that the information is confidential – we will not share information without their permission. Members can wrongly believe that if they do not

participate they may lose their services. An important assurance for this letter is that refusal to participate will not affect their services.

Moving information such as these assurances to the initial notification letter helps individuals to be comfortable with the process. We also let them know in advance that we can provide language services, or other assistive services as needed.

The readability statistics for this modified letter are as follows:

- Passive Voice Sentences: 0%
- Flesch/Kincaid Readability Score: 76
- Grade Level: 6

SUGGESTED MEMBER NOTICE LETTER

This version of the letter meets the ease of reading standard of three sentences per paragraph, an average of 14 words per sentence, and an average of four letters per word. These statistics indicate that it will be easy for Waiver participants to read the letter and understand it without assistance from others. In this way, we constantly look for ways to support individual autonomy and independence.

We will review the survey instrument and the letters and forms, and make recommendations to the Agency for changes if needed. Once the Agency reviews and approves the materials, we will update the policies and procedures to include the new documents.

RESPONSE TO RFP ITEMS

1. *The Contractor shall manage, monitor and maintain the Iowa Participant Experience Survey (IPES) or redesigned tool to include but not limited to:*
   a. Tool examines the experience of program members.

b. Areas of member experience examined include, but are not limited to: satisfaction, safety, service utilization, choice, and dignity.

The voice of the individual is an important component of monitoring and improving services. For Home and Community Based Services collecting information about the individual's experience provides essential feedback concerning:

- Satisfaction with services and providers.
- Ability to choose services based on individual goals.
- Achievement of goals that are important to individuals.
- Perception of an environment of respect and dignity.
- Utilization of services and relationships with providers.
- Individual safety in settings and while using services.

c. Revisions or newly developed components of the survey tool must be approved by the Agency and statistically validated.

As with all program materials, we will submit any revisions or new materials to the Agency in advance for review and approval. We will provide the updated versions at least 30 days prior to proposed implementation, and after review, will finalize the materials as the Agency approves. If needed, we will then train staff members. We also suggest if we update the survey instrument itself, we also review it with the Advisory Committee(s) prior to submission to the Agency. That way, we can assure that we reflect the interests and perspectives of stakeholders throughout the process.

d. Provide initial and ongoing training to contract staff on reliable interviewing techniques for the member survey tool being used.

Our culture of exemplary customer service is a foundation for person-centered interviewing techniques. We provide an orientation for each employee on our customer service expectations during orientation. Our proposed approach includes having HCBS Specialists conduct all interviews. These staff members will have an in-depth understanding of the program and CMS HCBS Quality Assurances. Knowing *why* we collect the information improves the ability of interviewers to document accurate responses. For the HCBS Specialists who will conduct the interviews, we will provide additional training, shown in Table 4.4-30.

Table 4.4-54. Overview of Training for Interviewers

Specialized training on interview techniques and project parameters reduces bias and improves reliability.

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

This level of training is appropriate for new HCBS Specialists, and as a refresher if staff did not take part in interviews for six months or more. We will also conduct a shorter orientation prior to each survey cycle that will include steps 4, 7, 8, 9, and 10 at a minimum.

INTERVIEWER RELIABILITY

The ability of interviewers to administer questionnaires the same way is critical to meaningful results. We use rehearsed interviews and supervisor observation to measure interviewer reliability. The rehearsed interview uses a gold standard set of results based on standard factors and circumstances that should generate the same results and flags across interviewers. If interviewers do not score at least

[redacted]

85% agreement, we discuss expected results, provide additional training on problem areas, and remeasure.[3]

The questionnaires include both categorical responses, which tend to be more reliable, and commentary, which tends to be less reliable. We take this issue into account in our assessment of reliability to set a standard that is high enough without creating an unrealistic goal for interviewers.

For ongoing measurement and training, we use supervisor observation of the interviewer. We will request permission from the member before including an observer in the interview. The Supervisor will also record the interview, and compare the "super-rater" interview results with those of the HCBS Specialist. We expect an agreement of 85% for this aspect of reliability as well, and will conduct training and re-measurement to address areas of under-performance. Specialized training and monitoring is appropriate for HCBS Specialists with quality concerns in their performance. That process involves expanding the interview walk throughs and increasing supervision until they meet the requirements.

e. Ensure representative samples of members are interviewed each period at a 95% confidence level.
f. Work with other units in the Agency to ensure representative sample.

The purpose of conducting interviews of HCBS members is to draw conclusions about aspects of their experience that are successful in achieving their goals and other aspects that may need individual and/or program level changes. For the conclusions to be meaningful, they depend on interview results that represent the overall population. The number of responses needed to generalize results depends on the confidence level and the margin of error. A confidence level of 95% and margin of error of 5% means the results will be highly representative of the population. The effective sample size to achieve 95% confidence level across all Iowa Medicaid programs is 335 individuals.[4] That means that we need to have at least 335 individuals participate in the interview process. The other factor that affects generalizability is the response rate, or the percent of individuals in the random sample who participate in the process.

KEPRO FINDINGS: The updated HCBS Quarterly Report suggests a 60% rate. We show the number of enrollees by waiver, with the total, effective sample size (respondents required), and the random sample.

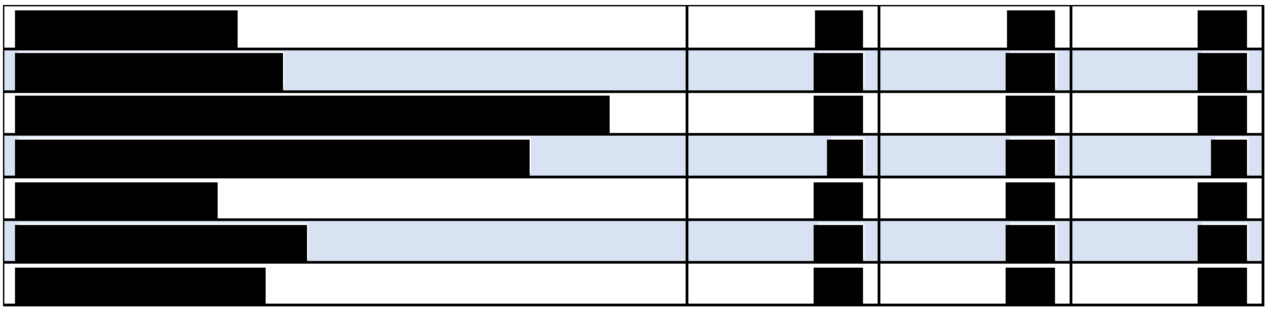
A recently completed research study on the development of the HCBS CAHPS survey found that response rates varied according to individual characteristics and type of interview, with in-person interviews generating a slightly better response rate than telephonic interviews. Individuals enrolled in programs for individuals who are frail elderly and/or have a physical disability had the highest response rate, with individuals who have an intellectual/developmental disability having the lowest response rate. The study reported the average response rate across all programs and methods was 22%. Table 4.4-55 shows the response rates for the 2015 field test of the HCBS CAHPS instrument.

Table 4.4-55. Response Rates by HCBS Program and Type of Interview[5]

Individual preferences for in-person or telephonic interviews align with their personal eligibility factors.

[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

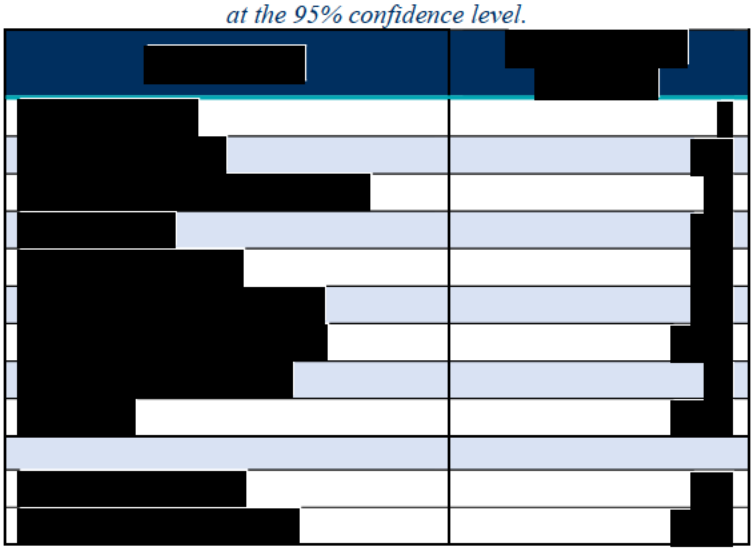


*The "overall %" column in Table 4.4-31 is based on the distribution of respondents taking the survey in-person versus by phone. The response rate is a weighted average of the two modes, not a straight average. For the pilot and field tests these data reflect, the development team randomly assigned approximately 80 percent of participants in each program to the in-person mode. However, because participants were permitted to switch modes if they preferred the other mode, slightly under 75 percent responded via the in-person mode.

ACTIONABLE RECOMMENDATIONS: The rates we show in Table 4.4-55 suggest that we could expect about a 22% response rate. *Therefore, the random sample size is 1,595 individuals, or about 60% of waiver enrollees. We show the number of enrollees by waiver, with the total, effective sample size (respondents required).*

Table 4.4-56. Waiver Enrollees and Sample Sizes

We assure generalizability of results to the population with a random selection that will generate an effective sample at the 95% confidence level.



MONTHLY SELECTION

We will work with the Agency during Transition to define the monthly, quarterly, and annual volumes to ensure that results are representative of the population. Additionally, we will also discuss how the sample might be stratified by program type to improve the ability of results to represent individuals in each waiver. For example, we might need a smaller sample from the Elderly, Health and Disability, and Physical Disability waivers and a larger sample from the Intellectual Disability Waiver to achieve representative results across the different populations.

WORKING WITH OTHER AGENCY UNITS

We will collaborate with other Agency units to throughout the process to assure that we:

- Have a clean data set from which to select the sample.
- Can receive background information requested from Case Managers on a timely basis.
- Receive assistance if needed recruiting participants from each waiver for the interview process.
- Understand the specific provisions of each waiver that may affect communication and responses.

The HCBS Operations Manager will be responsible to develop working relationships with relevant units to facilitate the IPES process. This approach will include a formal point of contact for the unit to be the recipient of emails and other communications, and assist us with coordinating activities with their units.

Coordination will include, for example, notifying the point of contact when we are ready to select the sample; notifying the unit of the sample size; and soliciting input and assistance when there are communication issues with enrollees, representatives, and/or Case Managers.

IPES PROCESS

HCBS policies and procedures include the administrative process for the IPES. In reviewing this procedure, we identified several areas to examine during Transition that could improve efficiency and the quality of results. **Our recommendations include:**

1) Automate document generation and handling, such as creating notifications to Case Managers with requests for background information on enrollees.
2) Create an online form for Case Managers to provide information about individuals in their workload, to streamline responses, reduce turnaround, and improve data quality with field edits.
3) Emphasize in-person interviews for all waivers, with the exception of the Intellectual Disability and Brain Injury Waivers unless local response rates show both methods are equivalent.
4) Expand the protocol to address the ability of individuals who know the person best to assist with responses for individuals who have communication limitations. Not allowing this assistance could result in the individual stopping the interview or refusing it completely.
5) The same staff members conduct all interviews. Currently, Specialists conduct in-person interviews and Assistants conduct telephone interviews. This difference could create variation in responses that bias results. Therefore, either Assistants or Specialists conduct interviews. We recommend that HCBS Specialists conduct the interviews.

g. Report findings to the Agency on a monthly, quarterly, and annual basis.

Our report will use the template we propose in **Error! Reference source not found.**, with the addition of a discussion specialized to survey methodology, including:

- Discussion of the sampling frame and methodology.
- Analysis and comparison of response rates by waiver program, to validate assumptions and improve the accuracy of sample size estimates.
- Analysis and discussion of individual factors in the non-response group. This discussion is necessary to be able to assess the extent to which the response group is representative of the population, even if it is large enough in volume.

2. The Contractor shall develop appropriate and universal follow up for responses that are flagged to include but not limited to:
a. Established per design of the member survey tool and as approved by the Agency.

Follow up to interviews has to occur when the interviewer observes issues that are flags. **ACTIONABLE RECOMMENDATIONS;** *Attachment D of the IPES procedure is a Case Manager letter that details issues*

and/or events that the interview process may uncover, and which represent "flags." Those flags (and our recommendations for additions in green italics) are:

1) Utilization and access to services
   - Member is not receiving any/all of their services.
   - Staff does not spend all the time with the member that they are supposed to.
   - Staff is doing things the member does not like, and when the team was notified nothing has changed.
   - Member has gone without medicine in the last twelve months because staff did not help them.
   - Member needs special equipment or changes to the home and has not told anyone about this need.
   - Member needs special equipment or changes to the home, has told someone about this need, but has not received help with this need.
   - The service(s) the member receives does not help them manage their stress and stay well.
   - *Member's assessment does not identify current service needs.*
   - *Member's request for a change in provider(s) is outstanding after 30 days.*
2) Health and Safety
   - Member does not feel safe but has not told anyone on their team.
   - Member does not feel safe with the people they live with.
   - Member does not feel safe where they live.
   - Member was restrained within the last two years and did not tell anyone on their team.
   - Someone has hit or hurt the member in the last two years.
   - Member does not know what to do if someone is hurting them.
   - *Member's living situation includes health and safety risks, such as inadequate stair rails, loose rugs, or other risks.*
3) Crisis and Emergency Planning
   - Member feels there are stressful things in their life that can lead to a personal crisis but has not talked with anyone about managing them.
   - Member does not have a plan for managing stress written down for them.
   - A plan has not been written telling others how to help the member if they become upset.
   - The plan that has been written telling others how to help the member if they become upset does not work.
   - Member's plan for managing stressful life situations does not work for them.
   - Member's caregiver is experiencing stress and may need respite assistance.
4) Person-centered Services
   - Member did not report participation in service planning.
   - Service Plan needs updated member goals and objectives.
   - IDT did not solicit information about member opinions and preferences.

We added flags to the existing set to reflect observation of safety risks and caregiver issues. These factors support our recommendation that HCBS Specialists conduct all interviews, preferably in person. HCBS Specialists, who will be Master's prepared Social Workers, will be able to observe and assess the member's situation with more depth than non-licensed staff, even if well-trained. Our rationale for adding flags about person-centeredness relates to CMS' focus on individuals having an active role in choosing and managing their waiver services. As with other components of the IPES, we will review and

discuss our recommendations with the Agency during Transition, and develop final documents to use for go-live.

b. 100% of flagged responses shall be remediated with a case manager or service worker within the 15 business days.

We will remediate 100% of cases with the appropriate party within 15 business days of the interview. The Case Manager letter lists the flagged concerns we identify during the interview. The HCBS Specialist will contact the Case Manager to remediate the case. If the issue involves a service worker, the HCBS Specialist will contact the provider agency to discuss our findings. The HCBS Specialist will:

- Explain the nature of our findings.
- Discuss the factors that resulted in a flag on the case.
- Determine the most appropriate steps to remediate the issue.
- Coordinate Service Worker and Case Manager activities when both have a role.
- Validate remediation with individuals, and make adjustments for their preferences.
- Request the remediation of the issue by a specific date, with written notice on completion.
- Follow up with the individual to ensure the remediation was timely and addresses their concerns.

We will assure remediation by using a tracking system to time the initiation and resolution of flags. Case Mangers and Service Workers will receive notification within two (2) business days of the interview, identifying the flag(s) and requesting assistance with remediation within three (3) business days. If we do not receive a response within that timeframe, the HCBS Specialist will follow up with a call to the respective parties and request an immediate meeting. After seven (7) business days, we will elevate the issue to the HCBS Operations Manager, who will request assistance at the Case Manager or provider agency level. After 10 business days, we will elevate the concern to the Agency. At all times we will collaborate in good faith to remediate the flag in the best interest of the member.

This aspect of the process supports our proposal that HCBS Specialists conduct the interviews, since they will be responsible to contact Case Managers and service workers/agencies. Their backgrounds will enable them to engage with Case Managers and service workers/managers as peers and experts, providing technical assistance for development of remediation strategies.

Note: HCBS Specialists will follow the interview protocol if they identify an immediate threat to the health and/or safety of the individual and contact KEPRO and the appropriate authorities. If necessary, they will remain with the individual until the situation is addressed, for example, after calling emergency services. Additionally, we will also contact the Agency when we identify a situation involving fraud and abuse.

c. Document the discovery, remediation and improvement associated with flagged responses in an electronic database, or equivalent.

The HCBS Specialist will document all of these steps in the system for reporting and future analysis of patterns and trends. The HCBS Specialist uploads the interview template to the IPES Database, and the HCBS Assistant will use the IPES Survey Tracking system to document the process.

d. Develop communication strategies with case managers and service workers to ensure improvement of the quality of life and services for members interviewed.

Case Managers and service workers are on the front lines of engagement with all members, not only those we interview. Communications therefore have to be in the context of an ongoing relationship of trust and mutual respect between us for specific strategies to be successful. We build that relationship by:

1) Hiring HCBS Specialists and other HCBS staff with experience as Case Managers and service workers in Medicaid HCBS programs. Staff members who were "one of us" have an understanding of the roles and challenges of Case Managers and service workers. That background makes our communications efforts more realistic and credible.
2) Keeping Case Managers and service agencies "in the loop" about survey activities, including requesting input into the interview tool, coordinating interviews with Case Managers and service agencies, and including easy to access and use information on the HCBS website.
3) Using a member-centered approach to remediating flags. The goal of Case Managers and service workers is the success of the member in the community setting. Sharing that goal as a common aim means we work to resolve process, documentation, and coordination issues. As partners with Case Managers and service workers, we focus on the member. That focus makes our communication strategies positive and problem-solving.

e. Report findings to the Agency on a quarterly and annual basis.

Using our suggested format in **Error! Reference source not found.**, we will provide our findings and recommendations to the Agency on a quarterly and annual basis. Within the overall activity of the IPES, we will include a section for discussion of interviews with flag. This section will provide:

- Unduplicated Number of interviews with flags, and percentage of all interviews with flags.
- Number of flags, and average flags per interview (of all interviews with flags).
- Number of flags by type (for example, 1-4 discussed in Section 4.4.5.2.a), and percent of total.
- Timeframes for remediation by span of business days, e.g., three, five, seven, nine, etc.
- Summary of remediation's by type.
- Discussion of identified systemic issues and recommendations for improvement.
- Cases escalated to HCBS Operations Manager and Agency, including recommendations to avoid escalation in the future.

3. The Contractor shall make written recommendations to the Agency related to member surveys to include but not limited to:
a. Recommendations identify system improvements and best practices in member surveys.

Our expert Health Intelligence team will conduct detailed analysis of the survey instrument, administration process, and results to identify opportunities for improvement as part of our reporting process. For example, from our preliminary review of selected tools (Consumer + CCO, Family), process, and staffing we have suggestions for the Agency to consider during the Transition period:

1) Survey Instruments: These instruments vary according to the individual interviewed.
    a. We suggest that the header be modified to include either the file name or the participant type to ensure selecting the right questionnaire.
    b. It appears that the two instruments we reviewed asked about a plan only if individuals responded "Yes" to the question about restraint. We suggest asking about emergency or crisis plans as a standalone item.
    c. We noted that the questions do not mention member goals, which provide an important framework for members to interpret their experiences. Also, consider asking adolescents about choices as part of the CMH interview, since teens have the ability to make choices and may have a better service experience if they have a choice in the services they receive.
    d. We also suggest considering an item that addresses knowledge of and the need for respite services, since these services can help prevent caregiver burnout and adverse outcomes.

e. Other population specific items could be added, such as mention of supported employment for members whose waiver services include supported employment (Brain Injury and Intellectual Disability). This approach, while making the instruments very specific to the population, would help gather information for both cross-cutting analysis as well as detailed program analysis.

4) Administration and Process.

a. We suggested automating the selection and notification process as much as possible to reduce the amount of time it takes between receiving the sample and initiating interviews.
b. The administration method should focus on in-person interviews as much as possible in preference to telephone interviews. The questionnaires include opportunities for observation of the member's circumstances, which a telephone interview precludes.
c. Evaluate the sampling process and consider stratified sampling based on historic response rates to ensure results represent the various waiver populations, at least on an annual basis.
d. Evaluate response rates and focus on strategies to improve them if they are low, including improving contact information. Poor contact information is a major cause of low response rates, especially among minorities and individuals with developmental disabilities.

5) Staffing

a. Leverage the HCBS Project Assistant to set up interviews and make reminder calls to participants. Consolidating these activities into the Project Assistant role makes it possible for the HCBS Specialists to focus on conducting interviews in person.
b. Use MSW Social Workers (HCBS Specialists) to conduct the interviews. Some of the items and the ability to identify circumstances requiring flags depend on the judgement of the interviewer. For this reason, staff should have a relevant background and experience to be able to exercise informed judgement.

6) Analysis and Reporting

a. Include a formal non-respondent analysis to ensure respondent and non-respondent populations are similar enough for the results to represent the population as a whole.

f. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.

Collaboration is essential to provide a coordinated, consistent approach in all aspects of performance that are member-facing. The HCBS Specialists and HCBS Operations Manager will work with IME units to quality indicator reports to identify improvement opportunities, and then formulate recommendations that take into account relevant factors that affect individuals, providers, and the IME units. Since HCBS waivers and services are relatively to Iowa Medicaid, we suggest a monthly meeting during the first contract year to develop effective communications and collaborative working relationships.

g. Identify trends in member survey responses that could be used to drive systemic policy changes and improvements

Member survey responses are a rich source of information that we can use to identify meaningful policy issues and recommend changes, for example:

- Case Manager training to improve access to certain waiver services, such as respite or the Personal Emergency Response System, that may be under-utilized.
- Refinements in HCBS provider reviews based on flags and remediation results.

- Support to individuals for better use of Consumer Directed Option services, including oversight of staff and paying for services.

By discussing results with other IME units, our interpretation of trends and patterns will be more informed and our recommendations more practical and relevant. We will use these strategies, our internal and local experts, and emerging best practices to identify important trends in results of IPES surveys.

h. Data shall be derived from a centralized database, or equivalent, such that it can undergo replication for future reports.

We will add survey results to a central database and maintain the results over time. This approach will allow us to replicate results as needed for future reports, it will also allow us to identify and analyze trends over time at the program and service level.

e. Report recommendations to the Agency on a quarterly and annual basis.

We suggest using the report format we explain in 4.4.1.e and as approved by the Agency. This format includes an area to report recommendations at the program and policy level.

4.4.8 MFP SURVEYS (F.)

F. MFP Surveys. This scope of work will cease on March 31, 2020.

Money Follows the Person (MFP) is a successful federal initiative to rebalance Medicaid long-term care systems. It began in 2007 with the goal of increasing use of HCBS and reducing facility-based care by eliminating barriers that restrict use of Medicaid funds for non- institutional care. It also implemented procedures for quality assurance and improvement of HCBS. The Affordable Care Act extended MFP through fiscal year 2020, and expanded the definition of eligibility to include individuals who reside in an institution for more than 90 consecutive days (with the exclusion of short-term rehabilitation).

Iowa's MFP program focused on providing the opportunity for individuals to move out of ICF/IDs, with individuals in nursing facilities also potentially eligible. Services include transition services and enhanced supports for the first year. The May 2017 MFP Update[6] indicates that 600 individuals transition out of an ICF/ID or NF since September 2008, with 455 consumers successfully completing 365 days of MFP services and transitioning to the Intellectual Disabilities or Brain Injury Waiver. According to the RFP, there are currently 102 participants in managed care and six (6) in FFS.

Because of page limitations, we refer to our responses in 4.4.5 in this section, and describe areas where the survey process for MFP will be different.

1. The Contractor shall manage, monitor and maintain the MFP participant survey or redesigned tool to include but not limited to:

a. Tool approved by the Agency and CMS examines the quality of life of MFP participants in all areas designated by federal funding requirements. Revisions or newly developed components of the survey tool must be approved by the Agency and statistically validated.

Developers of the current tool to survey participants in Iowa's Money Follows the Person (MFP) program used a rigorous statistical and research process to create and validate the survey. Since the scope of work will end on March 31, 2020, we do not recommend making changes unless the Agency determines them to be essential. Given the small number of participants (102 in managed care and six in FFS), it would be difficult to validate changes to the instrument statistically.

[6] Available: https://dhs.iowa.gov/sites/default/files/MoneyFollows_the_Person_Update_May_1_2017.pdf Accessed: December 21, 2017.

i. Provide initial and ongoing training to contract staff on reliable interviewing techniques for the member survey tool being used.

We describe a thorough training approach for interviewers, which includes inter-rater reliability testing. We will modify the training content for the MFP survey, and conduct testing and retraining until interviews are ready to conduct interviews.

j. Interview MFP participants at a 100% level.

The MFP population is small, as we noted, and therefore we will interview all MFP participants. For MFP participants enrolled in managed care, we will coordinate the interview process with the MCOs and Case Managers, as appropriate.

Research indicates that individuals with intellectual disabilities (ID) or brain injury (BI) may prefer a telephone interview to an in-person interview. Individuals with BI had a response rate 8.5 percentage points higher for telephone interviews, for example. Since Iowa's MFP focused on individuals with ID and BI, we will discuss interview methods with the Agency and select the method that will generate the highest response rate. Individuals may choose, however, either method depending on their preferences. For a total population of 108, the effective sample to achieve a 95% confidence level, with a 5% margin of error, is 85, or about 80% of the population.

k. Collaborate with other units in the Agency to ensure representative sample.

Since we will interview 100% of the population, we will not select a sample. We will, however, coordinate with other units to ensure we are able to interview at least 80% of the participants. This response rate allows us to generalize the results to the MFP

l. Report findings to the Agency on a monthly, quarterly, and annual basis.

We suggest using the report format we explain in 4.4.1.e and as approved by the Agency. This format includes an area to report our findings at the program and policy level.

10. The Contractor shall develop appropriate and universal follow up for MFP survey responses that are flagged to include but not limited to:
- *a. Established per design of the MFP survey tool and as approved by the Agency.*
- *b. 100% of flagged responses shall be remediated with a transition specialist within 15 business days.*
- *c. Document the discovery, remediation and improvement associated with flagged responses in an electronic database, or equivalent.*
- *d. Develop communication strategies with transition specialists to ensure improvement of the quality of life and services for members interviewed.*
- *e. Report findings to the Agency on a quarterly and annual basis.*

We will flag responses that indicate issues with planned transition services and enhanced support services. The HCBS Specialist will contact the MFP transition specialist, and use similar techniques and timeframes to ensure we remediate 100% of the responses within 15 business days.

The same data repository will contain MFP survey responses and remediation information, with record identifiers to enable us to distinguish between IPES surveys and MFP surveys. We will then use these data to develop communications with transition specialists to ensure we can collaborate effectively throughout the interview and remediation process. We will then report our findings using the standard template.

11. The Contractor shall make written recommendations to the Agency related to MFP surveys to include but not limited to:
- *a. Recommendations identify system improvements and best practices in MFP surveys.*
- *b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.*
- *c. Identify trends in member survey responses that could be used to drive systemic policy changes and improvements*
- *d. Data shall be derived from a centralized database, or equivalent, such that it can undergo replication for future reports.*
- *e. Report recommendations to the Agency on a quarterly and annual basis.*

With a very small population, collaboration with IME units is an important aspect of our role in the MFP interview process. Close coordination with transition specialists will help us ensure a response rate of 80%, which we need for the results to be generalizable. Additionally, collaboration to interpret the data and identify relevant and practical policy recommendations is essential because the data set is not large enough to observe statistically significant trends or patterns.

We will limit the number of HCBS Specialists who conduct the interviews to make it easier for transition specialists and IME units to work closely with us. This staffing approach also ensures that we will be able to interpret the results to identify trends and patterns qualitatively, since the HCBS Specialists will in effect be MFP specialists. As we discussed above, we will enter and maintain the data in a central database, with an MFP identifier on each record to ensure we can differentiate between IPES and MFP participants.

We will also use our standard reporting approach for this task, as approved by the Agency.

4.4.7 HCBS WAIVER SLOT MANAGEMENT (G.)

G. HCBS Waiver Slot Management

1. The Contractor shall assign one full-time HCBS Slot Manager and one fully trained backup to assist the Agency with management and release of waiver slots to include but not limited to:

Iowa's seven HCBS Waivers make it possible for individuals to avoid institutional placement and receive services that support independence and choice. As of the most recent Waiver slot report, there are 5,307 individuals waiting for placement in Brain Injury, Child Mental Health, and Intellectual Disabilities waivers.[7] It is therefore important we manage waiting lists for these waivers on a timely and accurate basis to ensure Iowa members have equitable access to important services.

We will assign a full-time HCBS Manager and a full-trained backup to assist the Agency with this activity. These staff members will work closely with the Agency to manage and release waiver slots, using the Worker Information System Exchange (WISE) for that purpose.

We will assume responsibility to manage the waiting lists for Iowa's waivers using an approved slot management process consistent with the HCBS Slot Management Process, including releasing slots when the Legislature appropriates funding.

SLOT ALLOCATION PROCESS (BUY-DOWN)

a. Allocate slots based on waiver funding allocation and wait list characteristics.

The Slot Allocation, or buy-down, process releases waiver slots according to the number CMS approves, based on the waiver application and slots DHS requests as part of the waiver. Our Data Analyst will report the current waiting list for waivers to the DHS Budget Analyst. The Budget Analyst will then provide an initial analysis for the buy-down allocation, such as methodology for which slots to release first; assumed uptake or enrollment rate; and other factors the Budget Analyst may identify, such as the number of individuals on the waiting or historical release of slots for specific waivers, for example. Our goal will be to provide as much information as possible about the status of individuals on waiting lists for waiver services to help the Agency assure that access to these services is equitable and decisions represent the best interests of the individuals who are waiting for services.

b. Meet with Agency staff as necessary to determine distribution strategy and discuss status.

[7] Monthly_Slot_and_Wait_list_12.14.17.pdf Available: https://dhs.iowa.gov/sites/default/files/Monthly_Slot_and_Wait_list_12.14.17.pdf Accessed: December 21, 2017.

We will then meet with IME to discuss appropriate implementation and release of slots. The Data Analyst, or other HCBS staff, will document the decisions to implement slots by preparing a plan that details the number of slots for each waiver, according to the legislative appropriation, and the number of slots released on a weekly basis for each waiver. The HCBS Slot Manager identifies the next member eligible for a buy-down slot by running a weekly report.

Slots become available through this buy-down process when the legislature appropriates funding. Already funded slots may become available to waiting list members when they age out of the waiver or are deceased (an attrition slot). An attrition slot also becomes available again when an individual does not complete the process once notified that a slot is available, on a first-come, first-served basis according to application date and birth month if more than one member has the same, earliest application date.

When appropriations become available, the HCBS Slot Manager will begin the release of slots according to the implementation plan, using the first-come, first-served methodology.

c. Publish funding allocations on the website within 10 business days of the end of the reporting period.

This activity follows the process for Report G in the HCBS Slot Management Process. The HCBS Slot Manager will prepare the report for publication and submit it to the IME Policy Staff Designee or HCBS Unit Manager for approval. These staff members will determine if the report will be published. On approval of the report, we will forward the report to the IME Web Master for posting to the website.

d. Published status format must be accessible to the public and formatted as approved by the Agency.

The Agency currently publishes a report available to the public that summarizes waiver status (Report G, or Attachment B to the HCBS Slot Management Process). This report format is well-organized and legible, and we propose to continue using this format as approved by the Agency.

e. Report waiver slot and wait list data to the Agency on a monthly, quarterly, and annual basis.

f. Ad hoc reporting, upon Agency request.

We will use the summary report formats we discuss in item (d) to report waiver slot and wait list data by waiver, with reserved slots reported separately for relevant waivers. These reports will be available on a monthly, quarterly, and annual basis through electronic submission and hardcopy on request. In addition, we will maintain an online Dashboard in the Health Intelligence Center that includes the same figures, with the ability to examine individual records to examine records, for example, the earliest application date.